Know Your Benefits

v2

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Employers Dental Services
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MAGELLAN HEALTH SERVICES
Getting Better All the Time

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Walgreens Health Initiatives

FY 2009-2010

Maricopa County Employee Benefit Plan

Envision living "well" into the future...

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The Information in this booklet highlights the Maricopa County benefit plans for employees and their dependents.

This booklet is intended to provide you with information needed to make informed decisions regarding the selection of your benefits. The benefits described herein are summaries of the County's official plan documents and contracts that govern the plan. In the event of a discrepancy between the information in this booklet and the official documents, the official documents govern.

Maricopa County reserves the right to change or cancel its benefit plans, in whole or in part, at any time.

Participation in any of the County's benefit plans is not a contract of employment.

HOW TO OBTAIN BENEFIT INFORMATION

Information about the benefit plans is available on the Internet at *www.maricopa.gov/benefits* or on the Electronic Business Center (EBC)/Intranet at *ebc.maricopa.gov/ehi*.

Both of these Web sites are referred to as the Employee Benefits Home Page in this document.

You may also e-mail the Employee Benefits Division at *BenefitsService@mail.maricopa.gov* or, for enrollment and plan information, call 602-506-1010 from 8 a.m. to 5 p.m. MST Monday- Friday or visit the Employee Benefits Division located at 301 South 4th Avenue, Suite B100, Phoenix.

The Employee Benefits Division can assist you with general questions related to premiums, eligibility and enrollment, status changes, and benefit continuation while on or returning from a leave of absence (LOA) and/or upon retirement.

Please contact the specific vendor for answers to detailed benefit questions regarding coverage, costs and claim(s) payments. Vendor contact information is located in the "Who to Contact" section of this booklet.

The words "you" and "your," when used in this document, refer to the employee.

IMPORTANT INFORMATION

Carefully read all of the information in this guide.

Do not make a medical or dental election solely on the basis of a healthcare provider's participation with the vendor's network because physicians and dentists may stop participating during the plan year. If a specific physician or dentist is very important to you, consider selecting a product with out-of-network benefits such as an Open Access Plus (OAP) High or Low option or Choice Fund high-deductible medical plan and/or CIGNA or Delta Dental plans. Plans with out-of-network benefits allow you to use providers who do not participate with the vendor's network, at higher out-of-pocket costs to you. Additionally, you should not make your pharmacy plan election solely on the basis of specific medications on the preferred medication list because medication coverage status may change during the plan year and some medications may require prior authorization or step-therapy. For example, medications may change from preferred brand name level to a non-preferred brand name level which would cost you more, or may become available over-the-counter and therefore will not be covered under the pharmacy benefit.

Make your data-driven event (for example, new hire or newly eligible) election decisions carefully as once the enrollment period (30 calendar days from event date) expires, they cannot be changed until the next plan year starting on July 1, 2010. Make sure to click the "Submit" button on the Benefit Summary Page to finalize your elections. Once the "Thank You" page appears, your benefit enrollment is complete. Print your "Confirmation Page" as verification of your elections. Keep this "Confirmation Page" to compare with the "Confirmation Statement" that will be mailed to your home address on file with the Employee Records Division.

Review your "Confirmation Statement" immediately and contact the Employee Benefits Division within 30 calendar days from the date of your "Confirmation Statement", if you discover an error between the two documents. Only errors will be corrected. Your printed "Confirmation Page" from the Benefits Enrollment System will be accepted as verification of your intent of your enrollment elections in the event of an error.

Some plans require an election of a PCP with your initial enrollment. Watch for your new ID card in the mail and upon receipt, be sure to check the PCP. Contact your selected medical plan vendor to change your PCP, if applicable. If additional ID cards are needed, contact the vendor directly either by phone or through their Web site. See the "Who to Contact" section.

GLOSSARY OF TERMS

Benefit-Eligible: A full- or part-time employee (not a temporary employee) of Maricopa County who is scheduled to work at least 20 hours per week. Contract employees may also be benefit-eligible based on the terms of their contract.

Biometric Screening Program: Provides employees with screenings for: Blood Pressure, Total/HDL Cholesterol and Ratio, Glucose, Height/Weight, Body Fat Analysis, Waist Circumference and One-on-one Health Coaching Session that includes program referrals and health education/literature on screening results.

Body Mass Index (BMI): A number calculated from a person's weight and height. The formula is defined as (weight in pounds*703)/(height in inches^2). For example, if your weight is 135 pounds and your height is 61 inches your BMI is approximately 25.50 (125*703))/(61*61).

CIGNA Care Network (CCN): A high performing cost effective specialty care provider network that includes the following provider specialties: allergy/immunology, endocrinology, OB/GYN, cardiology, neurology, nephrology, neurosurgery, orthopedics/surgery, urology, general surgery, cardio-thorasic surgery, colon/rectal surgery, vascular surgery, hematology/oncology, ear/nose/throat, ophthalmology, rheumatology, infectious disease, gastroenterology and dermatology. These providers are identified by a Tree of Life Symbol in the CIGNA provider directory.

CMG (CIGNA Medical Group Network): A network of providers who are employed by CIGNA HealthCare of AZ who practice in the CMG facilities that are owned and operated by CIGNA. Primary and some specialty and ancillary care are provided at the CMG facilities. Some specialty care is provided through the OAP network when a referral is made by the CMG physician.

CMG High and Low Plan: A managed-care plan that requires members to use the CMG facilities for primary and most specialty and other services. Use of non-network providers or providers who practice in their own offices are not covered.

Co-insurance: A cost-sharing requirement under a health insurance policy, which provides that the insured will assume a percentage of the costs of covered services after payment of the deductible, if applicable.

Copay: A cost-sharing arrangement in which the insured pays a specified flat dollar amount for a specific service (such as $20 for an office visit). The amount does not vary with the cost of the service, unlike co-insurance, which is based on a percentage of cost.

Deductible(s): Under a health insurance policy, amounts required to be paid by the insured either before benefits become payable, after a portion of benefits have been paid or for a specific benefit, before benefits are payable.

Flexible Spending Account (FSA): A plan which provides employees with a way to set aside money on a pre-taxed basis to cover the costs of either health care expenses that are not covered under their health insurance coverage (medical, pharmacy, mental health, dental and vision) or dependent care expenses that enable the employee to work.

Group Insurance Qualified Status Change Form: A form provided by the Employee Benefits Division on which the employee requests to add or drop dependents due to a qualified status change.

Health Assessment (HA): A brief online questionnaire that analyzes the health risk of the employee.

Health Coaching Program: Coaches work one-on-one with employees to help identify goals and to embrace change.

Health Maintenance Organization (HMO): HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals and other health professionals, who participate in their network. The members of an HMO are required to use participating network providers for all health services, and many services must meet further approval by the HMO through its utilization review program. HMOs are the most restrictive form of managed care benefit plans because they manage and restrict the procedures, providers and benefits.

Health Plan: Includes medical, pharmacy, vision, behavioral health and substance abuse, and dental coverage.

Health Savings Account: A tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan.

High Option: A plan where premiums are higher than a low option plan because the insured shares less of the costs with lower copays.

In-Network (or Network, Participating Provider): Health care provided by a doctor, hospital, pharmacy or other health care provider with whom the plan has contracted to provide services at specified fees.

Insured (aka Member): A person or organization covered by an insurance policy.

Insurer (Insurance Company or vendor): A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

Low Option: A plan where premiums are reduced in comparison to a high option plan because the insured shares more of the costs in the form of higher copays and co-insurance.

Medical Waiver Payment: Compensation paid to the employee by the County if medical coverage is not elected because of enrollment in other eligible group health insurance. Waiving medical coverage means waiving coverage for all components of the medical plan, which includes medical, vision, pharmacy, and behavioral health and substance abuse benefits.

OAP (Open Access Plus) Plan: A plan that gives options to use a network or non-network physician/provider each time the insured needs medical care, and does not require a referral to see a specialist.

OAPIN (Open Access Plus) In-Network: A plan that uses a network of providers who practice in their own offices and independently contract with CIGNA. Non-network physicians/providers are not covered under this plan. The OAP In-Network also includes the CMG network. A referral is not required to see a specialist.

Out-of-Network (or Non-Participating, Non-Network Provider): Health care received from a provider who is not contracted with the insured's health plan network.

Out-of-Pocket Maximum: The maximum amount the insured pays each year for health care. The maximum may apply only to specific services such as inpatient hospitalizations. After this share of eligible expenses has reached the plan's out-of-pocket maximum per person or per family, the plan pays the full cost of eligible expenses for the rest of that plan year. The out-of-pocket maximum does not include any copays, pharmacy or mental health/substance abuse treatment expenses, or non-certification penalties. Each plan summary lists the expenses that count towards the out-of-pocket maximum.

Plan Year: July 1 through June 30

Preferred Medication List (aka Formulary): List of prescription drugs approved by a pharmacy benefit manager. Drugs on the preferred medication list are generally more cost effective and are as effective as other drugs that are non-preferred in the same therapeutic medication class. The list is available on the Employee Benefits Home Page.

Preventive Care Services: This includes all routine preventive services such as Well Baby Care, Well Child Care and Adult Preventive Care as identified by each plan in the plan summary.

Primary Care Physician (PCP): A physician who practices general medicine, family medicine, internal medicine or pediatrics.

Reasonable and Customary Charge (R&C): The prevailing charge of most other providers in the same or similar geographic area for the same or similar service. If the insured receives out-of-network services and the provider's fee is more than the R&C charge, the insured will have to pay the amount of charges above R&C. When care is received from an in-network provider, the eligible expenses are determined from the network provider's contracted rate.

Short-Term Disability (STD) benefits: STD pays a percentage of the insured's salary for up to 23 weeks after a 3-week waiting period if he/she becomes temporarily disabled due to sickness or injury and is not able to perform the essential functions of his/her job. The insured must be under the regular care and treatment of an appropriate provider.

Specialty Medication: Usually expensive drugs (oral or injectable) that are used to treat complex and rare medical conditions. These drugs may require special care and handling (such as refrigeration) and patient counseling due to their high risk of causing serious side effects or complications.

Sub-Acute Facilities: A hospital-based facility or a freestanding facility that provides a lower level of care (than acute care) as directed by your physician.

Term Life Insurance: Term life insurance covers a person for death benefits for a limited time (a term). In the case of the term life insurance coverage provided by The Standard, the term is conditional. You are covered as long as you are employed by Maricopa County. Term life insurance does not have any cash value.

GLOSSARY OF ACRONYMS

Abbreviations used throughout this booklet

AD&D: Accidental Death & Dismemberment	**EE**: Employee	**IRS**: Internal Revenue Service	**PML**: Preferred Medication List
ADP: Automatic Data Processing, Inc.	**EOI**: Evidence of Insurability	**LOA**: Leave of Absence	**PPO**: Preferred Provider Organization
AHCCCS: Arizona Health Care Cost Containment System	**FML**: Family Medical Leave	**MH**: Mental Health	**PSPRS**: Public Safety Personnel Retirement System
ARS: Arizona Revised Statutes	**FMLA**: Family Medical Leave Act	**MST**: Mountain Standard Time	**PST**: Pacific Standard Time
ASRS: Arizona State Retirement System	**FSA**: Flexible Spending Account	**NAIC**: National Association of Insurance Commissioners	**PTO**: Paid Time Off
BMI: Body Mass Index	**HA**: Health Assessment	**NEO**: New Employee Orientation	**RIF**: Reduction in Force
CCN: CIGNA Care Network	**HDL**: High-density lipoprotein	**NP:** Non-Preferred	**Rx**: Prescription
CMG: CIGNA Medical Group	**HIPAA**: Health Insurance Portability and Accountability Act	**NRS**: Nationwide Retirement Solutions	**SPD**: Summary Plan Document
COBRA: Consolidated Omnibus Budget Reconciliation Act	**HMO**: Health Maintenance Organization	**OAP**: Open Access Plus	**SSN**: Social Security Number
EAP: Employee Assistance Program	**HR**: Human Resources	**OAPIN**: Open Access Plus In-Network	**STD**: Short-Term Disability
EBAC: Employee Benefits Advisory Council	**HSA**: Health Savings Account	**OE**: Open Enrollment	**UV**: Ultraviolet
EBC: Electronic Business Center (Intranet)	**ID**: Identification	**PCP**: Primary Care Physician	**WHI**: Walgreens Health Initiative
EDS: Employers Dental Services	**IRC**: Internal Revenue Code	**PHI**: Protected Health Information	

INTRODUCTION

Maricopa County recognizes your valuable contributions as an employee by offering comprehensive benefits for you and your dependents through the Employee Benefit Plan. Maricopa County is committed to helping you manage the high costs of health care, the risks of lost income due to illness and disability, and preparing for a secure retirement. The County's program provides:

Health, Life, Disability Plans & Flexible Spending Accounts

- A choice of six medical plans;
- A choice of two pharmacy plans (unless you elect the high-deductible health plan);
- A vision plan;
- A behavioral health and substance abuse plan;
- A choice of three dental plans;
- Basic and additional life, basic and voluntary accidental death and dismemberment, and dependents life and accidental death and dismemberment insurance plans;
- A short-term disability (STD) plan; and
- Health care (general and limited use) and dependent care flexible spending accounts.

Other programs and services available to you as an employee include:

- An employee assistance plan (EAP);
- A deferred compensation plan;
- Discounts on auto, home and renters insurance;
- A group legal plan;
- Arizona State Retirement System (ASRS) retirement plan, which include a long-term disability benefit, or Public Safety Personnel Retirement System retirement plan. If you meet the retirement system's eligibility criteria, you must be enrolled in and contribute to the applicable retirement plan.

ELIGIBILITY

Who's Eligible?

You can participate in the health, life, disability plans and the flexible spending accounts if you are a regular employee (except some contract employees as specified below) scheduled to work at least 20 hours per week.

For benefit plan purposes, "regular employee" is defined as a full-time or part-time employee who is not temporary, but who may be a contract employee. (When related to benefits administration, the definition herein of a regular employee differs from that which is used in the Merit Rules, available online at *http://ebc.maricopa.gov/pp/hr/tocs/EmpMerit_TOC.asp*.)

Employees working under specific contracts may or may not be eligible for benefits based on the terms of their contract. Contract employees may be offered health insurance benefits at the option of the appointing authority as long as the employee meets the same eligibility requirements of classified and unclassified employees. Contract employees scheduled to work less than 20 hours per week will not qualify for benefits except if the following applies:

> Employees who retire from the ASRS are statutorily limited to the number of hours they may work for the first year following their retirement date. If one of these employees returns to work within that time period, he/she may be offered only part-time benefits, regardless of the number of hours he/she is scheduled to work, at the option of the appointing authority while the employee waits for the one year limitation on hours worked to expire. At that time, the employee shall revert to meeting the requirements of all other contract employees.

Regular employees who are scheduled to work less than 20 hours per week, all temporary employees, and contract employees whose contract specifies they are not benefit eligible are ineligible to participate in the health, life, disability plans, and the flexible spending accounts. Health plans include medical, pharmacy, vision, behavioral health and substance abuse, and dental coverage.

Are Dependents Eligible?

Your legal spouse (does not include common-law, domestic partner, or significant other) and/or your unmarried dependent child(ren) are eligible for coverage under your health plans and/or dependents life and family accidental death and dismemberment insurance plans. Dependent child(ren) must meet the IRS definition of dependent children pursuant to IRC Section 152 and Maricopa County eligibility requirements below.

The term "child" means your unmarried natural child, stepchild, legally adopted child, child placed with you for adoption or child for whom you have been awarded legal guardianship. The term "dependent" means a child who meets one of the relationships listed above, and who meets the following criteria.

Dependent child(ren) under 19 or under 25 (if full-time student) is subject to all of the following:

1. Must be unmarried;
2. Must reside with the employee for more than one-half of the taxable year (January – December);
    a. Temporary absences due to school attendance do not violate this residency rule.
    b. Qualified Medical Child Support Orders or other court/administrative orders do not violate this residency rule.
    c. Your student dependent child will remain eligible during summer breaks from school provided that he/she will be attending school on a full-time basis during the fall term/semester.
3. Must be under age 19, or a full-time student and under age 25, or any age if permanently and totally disabled;
    a. For a child 19 or older, to be deemed a full-time student, the school he/she attends must be an educational organization defined in Code §170(b)(1)(A)(ii) that includes elementary, junior and senior high schools, colleges, universities, and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence schools, or schools offering courses only through the Internet. People who work "co-op" jobs in private industry as part of a school's regular course of classroom and practical training are considered full-time students. The child must be attending on a full-time basis except when on a medically necessary leave of absence of one year or less. The school will define and determine full-time student status.
    b. For a child who is permanently and totally disabled, the child must have been medically certified as permanently and totally disabled prior to his/her 19th birthday (or prior to his/her 25th birthday if disability began while a full-time student).
4. There is no earning income limit for the dependent child.

Additional rule for dependent child(ren) age 19 or under age 24 and a full-time student

The child must not have provided more than one-half of his/her support during the taxable year (January – December).

Additional rule for dependent child(ren) age 24, but under age 25 and a full-time student

The child must not have received more than one-half of his/her support during the taxable year (January – December) from the employee.

Verification of continued eligibility as a student or disabled child

You must provide verification of continued eligibility as a student to the ADP when a dependent turns 19 and at the beginning of each semester for full-time students. If your child is disabled and 19 or older, CIGNA will request verification of disability at frequencies determined by the type of disability. Failure to provide the requested verification within the timeframe specified in the request will result in termination of dependent coverage and loss of COBRA rights for the dependent.

Full-time students are eligible for coverage through the summer as long as they enroll and attend classes in the fall term/semester on a full-time basis. Should your child not return to full-time student status at the fall term/semester, the child will be deemed retroactively ineligible on the last day of the pay period following the child's last day of school attendance.

You are responsible for ensuring that only eligible dependents are enrolled on your benefit plan and immediately notifying the Employee Benefits Division when your dependents become ineligible. **You will be liable and responsible for the full cost of claims paid for your dependent after he/she became ineligible. Failure to notify the Employee Benefits Division within 60 calendar days of ineligibility forfeits the dependent's rights to COBRA coverage continuation.**

COVERAGE AND ENROLLMENT

When does coverage begin for newly eligible employees?

You have 30 calendar days from your event date (date of hire for a newly hired employee, effective date of employee going from a benefit ineligible status to a benefit eligible status or date of hire for an elected official) to select and submit your benefit elections online through the Benefit Enrollment System at *https://portal.adp.com*. To prevent a retroactive premium adjustment to your paycheck and to preserve your choice of benefits, online enrollment should be completed and submitted as soon as possible within the 30-day period. Premium starts accruing on the first day of the pay period that includes your coverage effective date and is not pro-rated. Refer to the Enrollment Worksheet Example and the "Online Benefit Enrollment System Instructions" sections for details.

New Hire

Benefit coverage for a newly hired employee begins the first day of the month following the date of hire, except for FSA coverage, which begins on the date the election is processed by the Employee Benefits Division, and life insurance that becomes effective at different times depending on whether it is contributory or non-contributory, if EOI is required, and if the application is made outside of the 30-day enrollment period. Benefit coverage for a re-hired employee with a break of employment of less than 30 calendar days begins the first day of the pay period following benefit termination so that there is no gap in coverage.

Benefit Ineligible to Benefit Eligible Status
Benefit coverage for an employee whose change in employment status renders him/her benefit eligible, such as going from temporary status to regular status, begins the first day of the month following the status change, except for FSA coverage, which begins on the date his/her election is processed by the Employee Benefits Division, and life insurance that becomes effective at different times depending on whether it is contributory or non-contributory, if EOI is required, and if the application is made outside of the 30-day enrollment period.

Default Coverage
If you do not complete enrollment online through the Benefit Enrollment System within 30 calendar days of your newly eligible or new hire date, your medical coverage will default to the CIGNA Choice Fund Health Savings Account plan for employee only coverage as a tobacco user and as not participating in Biometric Screening and the Health Assessment. Your basic life insurance coverage will be one times your annual salary rounded up to the next thousand to a maximum of $500,000. Your default coverage will be effective as explained in the New Hire or Benefit Ineligible to Benefit Eligible Status sub-sections above.

Can I change my benefits once I've submitted my benefit elections?
Yes, for data-driven events (for example, new hire or newly eligible) entered in the Benefit Enrollment System, you may change your benefits during the enrollment period (30 calendar days from event date). Once the enrollment period expires, changes to your benefit elections or to the default coverage assigned to you will not be allowed until the next open enrollment period for the next plan year. However, if you were employed by Maricopa County, terminated employment and then were re-hired within 30 calendar days, the benefit elections in place before your termination will be reinstated, with no option of changing your elections.

Decreases to additional life insurance and additional AD&D are allowed at any time. Decreases to dependents life insurance may only be made during open enrollment. Application for additional life insurance may be made at any time, as long as EOI is provided.

Open enrollment occurs at times designated by the Employee Benefits Division. The next open enrollment will be May, 2010 with benefit elections being effective on July 1, 2010. Open enrollment dates are posted in advance on the EBC/Intranet and communicated to each department via *e*Nouncements*. Please check with your department HR Liaison, Employee Benefits Advisory Council (EBAC) member or the Employee Benefits Division to obtain specific dates of the next open enrollment period.

If you have a qualified status change as defined under the IRC Section 125 during the plan year, certain changes are allowed. These are explained in the "When Can Changes be Made & When Are They Effective?" and "What is a Qualified Status Change?" sections.

WAIVING INSURANCE COVERAGE

Waiving medical insurance package
If you do not wish to enroll in coverage under the County's medical insurance package, you must waive coverage under the County's plan by submitting your request within the enrollment period via the Benefits Enrollment System when newly eligible or on a Group Insurance Qualified Status Change Form at the time of a status change. Failure to submit your request to waive coverage during your new hire/newly eligible enrollment period will result in default coverage as explained in the "Default Coverage" sub-section above. Refer to the "Important Information" section regarding the time limitation for correction of enrollment errors.

If you elect to waive the medical insurance coverage, you relinquish County medical package coverage during the current plan year, which includes medical, behavioral health, substance abuse, vision, wellness and pharmacy benefits. However, Maricopa County offers separate vision, dental, and/or additional life insurance to employees who elect to waive the medical insurance package.

Should you decide to waive coverage under the County's medical package because you are covered under other eligible medical insurance, you may qualify for taxable compensation. However, employees may waive enrollment in the County's medical package (even if they are not covered by other eligible medical insurance) and opt not to receive the compensation for waiving.

Compensation for waiving medical insurance package
The County will compensate you $50.00 the first and second paychecks of each month if you are a regular employee scheduled to work at least 30 hours a week or if you are a contract employee with full-time benefits and you waive the medical insurance package coverage because you have coverage under other eligible medical insurance. In no case is a payment made for the third paycheck of the month or if you do not have payable hours reported during a pay period.

In order to waive the medical insurance package and receive the medical waiver payment, you must provide proof that you are covered under other eligible medical insurance such as your spouse's plan, an individual policy, or Medicare. (Coverage under the Arizona Health Care Cost Containment System (AHCCCS) does not qualify as eligible medical insurance coverage and therefore does not qualify you to receive the medical waiver payment.) Proof must be submitted to the Employee Benefits Division when you initially waive the County's medical package or have a qualified status change within 30 calendar days of your benefit effective date or status change. The waiver payment expires annually or if you experience a qualified status change and elect County medical coverage. Proof must be submitted annually by June 1 for the next plan year to continue receiving the medical waiver payment.

Proof must identify you as a covered member and include the name of the primary insured, the insurance company's name, address,

and phone number, group name and number, member identification number and coverage effective date. Complete the "Verification of Insurance Form for Medical Waiver Payment" and mail or fax this information and a copy of your insurance card to the Employee Benefits Division. The form is located on the Employee Benefits home page on the EBC under the "Looking for a Form?" area.

Waiving other insurance coverage when newly eligible

You may elect to waive any or all of the following when you are newly eligible. However, enrollment into the plans following your initial eligibility date is limited.

Short-term Disability: You must wait until the next scheduled open enrollment to elect coverage regardless if you have a qualified status change.

Dental Insurance: You must wait until the next scheduled open enrollment period to elect coverage, unless you experience a qualified status change that is consistent with the need for dental coverage. Refer to "What Coverage Changes Can I Make During the Plan Year?" section.

Additional Life: You may elect or apply for coverage during the plan year. See "Additional Life and Voluntary Accidental Death and Dismemberment (AD&D) Insurance" sub-section in the "Life Insurance Plan" section for details regarding evidence of insurability requirements.

Dependent Life: You may elect this coverage if you experience a qualified status change. See "Dependents Child and Spouse Life Coverage" sub-section in the "Life Insurance Plan" section for details regarding evidence of insurability requirements.

Flexible Spending Accounts: You must wait until the next scheduled open enrollment to elect coverage, unless you experience a qualified status change where you or a dependent lost eligibility to continue participating in a flexible spending account, or attained eligibility where such change is consistent with the need for a flexible spending account. Refer to the "What Coverage Changes Can I Make During the Plan Year?" section.

HOW TO ENROLL WHEN YOU'RE NEWLY ELIGIBLE

You should attend a New Employee Orientation (NEO) meeting to receive benefit plan information. You can complete your enrollment within 30 calendar days of the new hire or newly eligible event online through the Benefits Enrollment System accessed through *https://portal.adp.com*. Instructions for online enrollment are provided in the "Online Benefit Enrollment System Instructions" section. It is in your best interest to complete and submit your online enrollment as soon as possible. Refer to the "When Does Coverage Begin for Newly Eligible Employees?" section for more information.

If you are not scheduled to attend a NEO meeting, you have the following additional enrollment options:

1. Ask your department's HR Liaison for enrollment information.
2. Go online to the Employee Benefits Home Page to obtain the benefit plan information you need to make your choices.
   a. The EBC/Intranet address is: *http://ebc.maricopa.gov/ehi*
   b. The Internet address is: *http://www.maricopa.gov/benefits*
3. Contact the Employee Benefits Division via Outlook e-mail at *BenefitsService@mail.maricopa.gov*.
4. Call the Employee Benefits Division for information at 602-506-1010.
5. Visit the Employee Benefits Division at 301 S. 4th Ave., Suite B100, Phoenix, AZ 85003.

WHO PAYS FOR BENEFIT COVERAGE?

Employer contribution

Maricopa County makes a generous contribution toward the cost of your medical and dental plans. You have the option of selecting medical coverage from CIGNA, pharmacy coverage from Walgreens Health Initiatives (except for the Choice Fund HSA plan that has pharmacy coverage through CIGNA), and dental coverage from one of three dental vendors: Employers Dental Services (EDS), Delta Dental or CIGNA Dental. The medical plans are described in the "Medical Plans" section. The dental plans are described in the "Dental Plans" section.

If you are a regular employee normally scheduled to work 30 or more hours per week or if you are a contract employee with full-time benefits, you will receive the maximum Maricopa County contribution towards your premium for the medical package (medical, vision, pharmacy, and behavioral health) for you and your dependents. You pay the "Full-time Premium".

If you are a regular employee scheduled to work 20 to 29.99 hours per week or if you are a contract employee with part-time benefits, you will receive a lower Maricopa County contribution toward your premium for you and your dependents. You pay the "Part-time Premium".

The County contributes the same amount toward your dental elections for the EDS plan regardless of your weekly scheduled hours. If you are a regular employee scheduled to work 20 to 29.99 hours per week or if you are a contract employee with part-time benefits and elect dental coverage through Delta Dental or CIGNA Dental, the County contribution is lower. You pay the "Part-time Premium". If you

are a regular employee scheduled to work 30 or more hours per week or a contract employee with full-time benefits, you pay the "Full-time Premium".

It is the department's responsibility to ensure that the applicable time is reported for payroll processing each pay period, even if the employee is on an unpaid leave of absence, in order for the employer contribution to be calculated and paid.

Employee contribution

When you elect benefits initially and during open enrollment (including passive open enrollments), you authorize the County to deduct the current employee benefit premiums from your paycheck for each benefit option you elect, and from any applicable Short-term Disability payments you might receive in the future. Payroll deductions will be made from the first two paychecks of each month, 24 paychecks per year. However, since there are 26 paychecks per year, two paychecks have no benefits deductions, with the exception of: flexible spending accounts; health savings account (associated with the CIGNA Choice Fund high-deductible health plan); auto, home and renters insurance; and if you have a balance due in arrears for any benefits. In such case, deductions are taken every paycheck.

You are responsible for reviewing your paycheck to verify that the correct premium deduction amounts are taken for the benefit options you elected. Please refer to the premium rates in the "Pay Period Premium Rates" section for each benefit elected.

If the premium deductions on your paycheck are incorrect in that you have been charged a higher amount due to an administrative error, and you identify the problem in writing to the Employee Benefits Division within six months from the date the error began, your premiums will be adjusted retroactively to reflect the correct amounts from the date of the error and refunded to you and your department, at the department's request. Incorrect premium payments resulting from you not notifying the Employee Benefits Division within 30 calendar days to remove an ineligible dependent will not be refunded to you or your department until a full claims audit has been conducted to determine your liability. Administratively caused premium errors discovered after six months will be corrected on a prospective basis with no refund on the overpaid premium to you or your department.

Regardless of when an error is discovered, if your premium deduction is incorrect in that you have been charged a lower amount than you should have paid, your premiums will be adjusted retroactively to the date of the occurrence and you and your department will be responsible for the cost of the underpaid premiums.

Deductions for the medical package (medical, vision, pharmacy, and behavioral health), dental and health care and/or dependent care FSAs reduce your taxable income, thus saving you money that would otherwise be paid in taxes. This tax advantage is provided under and follows the provisions of IRC Section 125.

DO BENEFITS CONTINUE WHILE ON AN UNPAID LEAVE OF ABSENCE?

General

When you take an approved unpaid leave of absence (LOA) (e.g. personal, medical or military leave) from your position, your benefits will continue for a designated period of time, depending on the type of leave. See sub-sections below for details. Since an unpaid leave of absence is a qualified status change, you may elect to revoke some or all of your benefits during your leave. See "Discontinue benefits while on LOA" sub-section below.

Military Leave

If you are going on military leave, refer to the Military Leave policy HR2417 available online at *http://ebc.maricopa.gov/pp/hr/pdf/h2417.pdf*. This policy requires you to complete a Notification of Uniformed Service Form indicating your intention to waive or continue benefits. Contact your department's HR Liaison to obtain this form. Complete and return this form to your HR Liaison, who will send it to Employee Records. If this form is not completed, your benefits will terminate. Before the military leave begins it is advisable that you work with your HR Liaison to update your contact information such as your address and phone number and provide a person's name and phone number who may be contacted in your absence.

Subject to and in conformance Military Leave Policy HR2417, USERRA and 10 U.S.C. § 1071 et. seq, employees who are members of the uniformed services have the option of obtaining medical and dental benefits for themselves and their dependents through the military health care system or may choose to continue their health and other benefits (restrictions apply to life insurance which must be ported or converted 180 days following the date the military leave of absence began) through Maricopa County's Employee Health Insurance Program at the active employee premium rate for a period of one year to begin when the employee is placed on Leave Without Pay after the commencement of active duty. To continue coverage, the employee must notify the Employee Benefits Division within 30 calendar days of the start of his/her unpaid leave, complete the Notification of Uniformed Service Form and make timely premium payments.

Upon conclusion of the one year coverage period, the employee is entitled to continue coverage through the Plan for an additional six months with the employee paying the entire cost of the premiums. Following this 18-month period, a COBRA notice will be mailed to the employee at his/her address on file in the PRISM system.

Life Insurance

Since Maricopa County pays 100% of the premium for your basic life and basic accidental death and dismemberment coverages, these will continue in force while you are on an approved unpaid LOA as follows:

- If you are not working due to injury, sickness, or pregnancy, or if you are on a military leave of absence you can continue to be covered through the end of the pay period following 180 days from the date your approved, unpaid leave status began.
- If you are on an approved personal leave of absence, you will be covered through the end of the pay period following 90 days from the date your leave of absence began.

If your leave extends past the coverage end date above and you wish to continue your basic and/or additional life coverage, you may elect portability or conversion coverage for yourself at a higher premium rate. You and a representative of the Employee Benefits Division must complete portions of the Member and Dependent Group Life Insurance Portability form. Refer to the "Life Insurance Plan" section for more details and the time frame in which the form and the premium are due. Dependent coverage can be maintained for as long as the reservist remains as an active employee and pays the applicable premium.

Discontinue benefits while on unpaid LOA

If you do not wish to continue some or all of your benefits, you must revoke coverage by completing a Group Insurance Qualified Status Change Form within 30 calendar days of the beginning date of your unpaid LOA. However, your STD coverage may not be revoked, unless you are part of a Reduction in Force (RIF) or you are on military leave. Contact the Employee Benefits Division or go online to *http://ebc.maricopa.gov/ehi* to the "Looking for a Form?" link to obtain a Group Insurance Qualified Status Change Form.

Refer to the "Return from LOA/Reinstatement of Benefits" sub-section for information on what process and time frame to follow in order for benefits to be reinstated upon your return to work.

Length of time benefits may be continued on unpaid LOA

If you want to continue your benefit coverage while on an unpaid leave of absence, you do not need to take any action. However, depending on the type of leave, the period for which you are eligible to continue benefits at the employee premium rate is limited to the following:

Approved Personal LOA: up to three months of premiums (6/24ths of the annual premium) in a rolling 12-month period starting the first day of your unpaid leave.

Approved Medical LOA: up to six months of premiums (12/24ths of the annual premium) in a rolling 12-month period starting the first day of your unpaid leave.

Military LOA: Refer to the Military Leave sub-section above.

Note: County (employer) contributions toward your medical and dental premiums may not extend beyond six months (12/24ths of the Annual Premium) in a rolling 12-month period by combining a personal leave with a medical leave. If you do not return to work after your FMLA leave entitlement has been exhausted or expires, **in certain situations the County may recover from you** the portion of medical and dental premiums it paid on your behalf while you were on such LOA, in accordance with federal regulations 29 CFR 825.213.

Premium payment while on LOA

The department has the responsibility to report the applicable leave without pay hours each pay period. This ensures that the employer portion of the premium continues to be collected from the department and that the employee portion of the premium goes into an arrears account. Arrears account balances are paid back through payroll deduction (the value equal to one pay period's deductions) when the employee returns to work. See the exception to this process in the Note below.

Note: If you are receiving short-term disability (STD) benefits, your payments for benefit premiums will be deducted from your STD payments on a pro-rated daily basis. The amount collected from the short-term disability payment will offset the amount in your arrears account upon receipt of such payment from the STD vendor.

If you terminate employment and you owe premiums, your benefits will be terminated retroactively to the end of the last day of the pay period in which premium was paid. **You will be liable and responsible for the costs of all claims paid for you and your dependents after your termination effective date or the amount of premium due, whichever is less**.

Note: In any case where your premium payments are not current, the insurance carrier may interrupt and/or terminate your benefits.

Continuation of coverage beyond county benefit eligibility

If you continue on an approved unpaid LOA beyond the point at which the County's contribution ends or if you terminate or resign employment (either voluntarily or involuntarily), you become ineligible for the County contribution to your medical and dental benefits. You may be eligible for continuation of coverage under the COBRA of 1985. See "When Does Coverage End?" sub-section below.

If you are receiving a payment for short-term disability at the time the County's contribution ends or if you terminate or resign employment, your premium for short-term disability coverage will continue to be deducted from your short-term disability payment throughout your disability benefit payment period.

Refer to the "Life Insurance Plan" section for conversion or portability coverage continuation information.

Return from LOA/Reinstatement of benefits

If coverage is terminated because of loss of benefit eligibility during your LOA, coverage may be reinstated upon your return to benefit-eligible active employment status if you complete a Group Insurance Qualified Status Change Form within 30 calendar days of returning. Failure to complete a Group Insurance Qualified Status Change Form within the 30-day period will result in loss of benefits for the remainder of the plan year. Refer to the "When Can Changes Be Made & When Are They Effective?" section.

WHEN DOES COVERAGE END?

Coverage ends the last day of the pay period in which you and/or your covered dependents cease to be eligible for coverage (for example, if an employee terminated or retired in the middle of a pay period, or an elected official's term ended mid-pay-period, coverage ends at midnight of the last day of that pay period) or for which a premium was paid (in the case of a terminated employee), whichever comes first. However, in the case of death, coverage ends the day following the date of death. You are responsible for notifying the Employee Benefits Division immediately when a dependent no longer meets the eligibility requirements listed in the "Are Dependents Covered?" section. **When coverage ends, you are liable and responsible for the cost of all claims and administrative costs paid or incurred for you and your dependents after the last day of coverage. Additionally, your dependent will lose eligibility to continue coverage under COBRA if notice of ineligibility is not received within 60 calendar days.**

If you and/or your covered dependent(s) ceases to be eligible for medical (including pharmacy, vision and behavioral health) and dental insurance or the health care FSA and you notify the Employee Benefits Division of such ineligibility within 60 calendar days, a COBRA notice containing enrollment and premium information will be mailed to you and/or your dependents at your address on file in the PRISM system. By enrolling in COBRA coverage within the allowed time frame and paying the total monthly premium and administrative charge, coverage for health care benefits [medical (pharmacy, vision and behavioral health), dental, vision only, and/or health care FSA] will continue retroactive to the date of ineligibility without a break in coverage through the period of COBRA eligibility.

WHEN CAN CHANGES BE MADE & WHEN ARE THEY EFFECTIVE?

General

If you have experienced a qualified status change event during the plan year, you may be eligible to add or drop (but not change) certain benefit elections, or add or drop dependents for the remainder of the plan year. The list of events that constitute a Qualified Status Change is provided in the "What Coverage Changes Can I Make During the Plan Year" section.

Qualified status changes must be verified through supporting documentation and must be consistent with the event as defined under IRC Section 125. Benefit election changes are consistent with status changes only if the election changes are necessary or appropriate because of the status change.

Requested benefit changes must be submitted on a Group Insurance Change Form within 30 calendar days of the change with supporting documents and provided to the Employee Benefits Division. Refer to the "Who to Contact" section.

What is a Qualified Status Change?

Examples of qualified status changes, as permitted by IRC Section 125, are listed below:

1. Change in status:
    a. Events that change an employee's legal marital status, including the following: marriage, death of spouse, divorce, legal separation, or annulment;
    b. Events that change an employee's number of dependents, including the following: birth, death, adoption, and placement for adoption. In the case of the dependent care spending account, a change in the age of qualifying individuals (e.g. child turns 13).
    c. Any of the following events that change the employment status of the employee, the employee's spouse or the employee's dependent:
        - termination or commencement of employment;
        - strike or lockout;
        - commencement of or return from an unpaid leave of absence (LOA) including FMLA;
        - change in residence or work site where eligibility no longer exists for the plan originally selected or where the employee or dependent becomes eligible in the new residence or work site;
        - change in the number of regularly scheduled hours to become benefit eligible or ineligible;
        - change in job or employment status that renders the employee benefit eligible or ineligible, such as moving from temporary status (benefit ineligible) to a regular status benefit-eligible position, or changing from a contract position with no benefits to a position with benefits.
2. Dependent satisfies or ceases to satisfy eligibility requirements such as attainment of age or change in student status;

3. Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order requiring accident or health coverage for an employee's child;
4. Significant cost or coverage changes.
5. Entitlement or loss of entitlement for Medicare or Medicaid (the Arizona Health Care Cost Containment System) more commonly referred to by its acronym **AHCCCS**, the Medicaid program in Arizona.

Effective Date of the Change

Below are the qualified family status changes and when the change becomes effective. For short-term disability and life insurance, please review the last two paragraphs of this sub-section.

Adding dependents, electing benefits if previously waived, or waiving benefits - due to birth, adoption, and placement for adoption

Employees may add a new dependent, waive if currently covered for benefits, or elect coverage if currently waiving coverage, when a family status change occurs. Changes in medical or pharmacy plans are not allowed. For birth, adoption or placement for adoption or to waive benefits due to these events, the effective date of coverage is the date of the event (date of birth, date of adoption, or date of placement for adoption). Premium changes associated with your qualified status change become effective the pay period in which the new coverage is effective.

In accordance with ARS 20-1057 B, if your medical coverage is under a CIGNA CMG or OAP plan, coverage of a newborn child, a child placed for adoption or an adopted child will be effective from the date of birth or placement and will continue for the following 30 calendar days if you are the primary insured according to Coordination of Benefits National Association of Insurance Commissioners (NAIC) rules. NAIC rules determine primary responsibility for coverage based on the earliest birthday in the year of the child's parents. There is no premium associated with coverage for the first 30 days as long as you do not enroll the child for ongoing coverage. In order for medical coverage to continue past the initial 30 days, you are required to pay a premium retroactively to the date of the event if you are not currently in the appropriate coverage premium level (i.e., if you are paying employee-only or employee-and-spouse premium instead of employee and family or employee and child premium).

You are required to complete a Group Insurance Qualified Status Change form and provide supporting documentation within 30 calendar days of the date of the qualifying event (date of birth, adoption or placement for adoption). The form and documentation must be delivered to the Employee Benefits Division. Refer to the "Who to Contact" section. **If you fail to provide the form and documentation within 30 calendar days of the event, your newborn will not be covered after the initial 30 calendar days and the next opportunity for adding the newborn will be during the next Open Enrollment period.**

Adding dependents, electing benefits if previously waived, or waiving benefits - due to all other family status change events (marriage, dependent attains or loses eligibility, court orders, legal guardianship, etc.)

Employees may add newly acquired or newly eligible dependents, waive if currently covered for benefits, or elect coverage if currently waiving coverage, when a family status change occurs. Changes in medical or pharmacy plans are not allowed. The effective date of coverage is prospective and is either the date the request is processed by the Employee Benefits Division or the first calendar day of the month following the date the required form and documents are received. Premium changes associated with your qualified status change become effective the pay period in which the new coverage is effective.

You are required to complete a Group Insurance Qualified Status Change form and provide supporting documentation within 30 calendar days of the date of the qualifying event (date of marriage, etc.). The form and documentation must be delivered to the Employee Benefits Division. Refer to the "Who to Contact" section. **If you fail to provide the form and documentation within 30 calendar days of the event, no changes will be allowed and the next opportunity for adding the newborn will be during the next Open Enrollment period.**

Losing Eligibility – all family status change events

When a dependent ceases to meet the definition of an eligible dependent, that dependent must be terminated from coverage. The dependent's coverage will end the last day of the pay period during which he/she lost eligibility. However, in the case of death, coverage ends the day following the date of death.

You are required to complete a Group Insurance Qualified Status Change form and provide supporting documentation within 30 calendar days of the date of the qualifying event. The form and documentation must be delivered to the Employee Benefits Division. Refer to the "Who to Contact" section. **When coverage ends, you are liable and responsible for the cost of all claims and administrative costs paid or incurred for you and your dependents after the last day of coverage. Additionally, your dependent will lose eligibility to continue coverage under COBRA if notice of ineligibility is not received within 60 calendar days.**

If you complete the form and submit it to the Employee Benefits Division within 30 calendar days of the event date, any premium overpayment will be refunded to you back to the coverage end date.

Short Term Disability (STD)

If you elect STD when you first become benefit eligible or during open enrollment, you may not change your election until the next

open enrollment even if you have a qualified status change. The only exceptions that may apply are if you are subject to a Reduction in Force (see HR2403) or called to active military duty.

Life insurance

If you elected additional life insurance and/or dependents life insurance, you have special rules that apply. These plans are not subject to IRC Section 125. Please see the special rules that apply to these life insurance plans, in the "Life Insurance Plan" section.

WHAT COVERAGE CHANGES CAN I MAKE DURING THE PLAN YEAR?

Provided below is a list of changes to your medical and dental insurance coverage that you can make in the event you experience a status change. The coverage change must be consistent with the qualified status changes.

1. Marriage
   - Add coverage for your spouse, child, or step-child
   - Drop coverage for your spouse, child, step-child or legal guardian
   - Elect coverage for yourself and your dependents, if you currently waive coverage (except STD)
   - Waive, if you elected coverage (except STD)
   - Increase coverage for health savings account, health savings account catch-up, additional life, additional AD&D, spouse life, child life, and flexible spending accounts
   - Decrease coverage for health savings account, health savings account catch-up, additional life, additional AD&D, spouse life, child life, and flexible spending accounts
   - Increase coverage level for additional life and additional AD&D
   - Decrease coverage level for additional life and additional AD&D
2. Divorce
   - Add coverage for your child
   - Drop coverage for your spouse, child, step-child or legal guardian. Former spouse and step-child(ren) are required to be dropped
   - Elect coverage for yourself and your dependents, if you currently waive coverage (except STD and Spouse Life)
   - Waive, if elected coverage (except STD)
   - Increase coverage for health savings account, health savings account catch-up, additional life, additional AD&D, child life, and flexible spending accounts
   - Decrease coverage for health savings account, health savings account catch-up, additional life, additional AD&D, child life, and flexible spending accounts
   - Decrease coverage level for additional AD&D
3. Death of Spouse
   - Add coverage for your child
   - Drop coverage for your deceased spouse and step-child (required)
   - Elect coverage for yourself and your dependents, if you currently waive coverage (except STD and Spouse Life)
   - Waive, if elected coverage (except STD)
   - Increase coverage for health savings account, health savings account catch-up, additional life, additional AD&D, child life, and flexible spending accounts
   - Decrease coverage for health savings account, health savings account catch-up, additional life, additional AD&D, child life, and flexible spending accounts
   - Increase coverage level for additional AD&D
   - Decrease coverage level for additional AD&D
4. Birth, Adoption, Placement for Adoption and Legal Guardianship
   - Add coverage for your child
   - Elect coverage for yourself and your dependents, if you currently waive coverage (except STD)
   - Waive, if elected coverage (except STD)
   - Increase coverage for health savings account, health savings account catch-up, additional life, additional AD&D, spouse life, child life, and flexible spending accounts
   - Decrease coverage for health savings account, health savings account catch-up, additional life, additional AD&D, spouse life, child life, and flexible spending accounts
   - Increase coverage level for additional life and additional AD&D

- Decrease coverage level for additional life and additional AD&D

5. Newly Eligible Employee
   - Elect coverage for yourself and your dependents, if you currently waive coverage (includes STD)
6. Legal Separation
   - Add coverage for your child
   - Drop coverage for your spouse, child, step-child or legal guardian
   - Elect coverage for yourself and your dependents, if you currently waive coverage (except STD, Spouse Life and Child Life)
   - Waive, if elected coverage (except STD)
   - Increase coverage for health savings account, health savings account catch-up, additional life, additional AD&D, child life, and flexible spending accounts
   - Decrease coverage for health savings account, health savings account catch-up, additional life, additional AD&D, child life, and flexible spending accounts
   - Decrease coverage level for additional AD&D
7. Dependent Gains Other Coverage
   - Drop coverage for your spouse, child, step-child or legal guardian
   - Elect coverage for yourself and your dependents, if you currently waive coverage (except STD)
   - Waive, if elected coverage (except STD)
   - Increase coverage for health savings account, health savings account catch-up, additional life, additional AD&D, spouse life, child life, and flexible spending accounts
   - Decrease coverage for health savings account, health savings account catch-up, additional life, additional AD&D, spouse life, child life, and flexible spending accounts
   - Increase coverage level for additional AD&D
   - Decrease coverage level for additional AD&D
8. Dependent Loses Other Coverage
   - Add coverage for your spouse, child, or step-child
   - Elect coverage for yourself and your dependents, if you currently waive coverage (except STD)
   - Waive, if elected coverage (except STD)
   - Increase coverage for health savings account, health savings account catch-up, additional life, additional AD&D, spouse life, child life, and flexible spending accounts
   - Decrease coverage for health savings account, health savings account catch-up, additional life, additional AD&D, spouse life, child life, and flexible spending accounts
   - Increase coverage level for additional AD&D
   - Decrease coverage level for additional AD&D
9. Dependent Becomes Eligible
   - Add coverage for your child or step-child
   - Elect coverage for child life and flexible spending accounts
   - Waive coverage for flexible spending accounts
   - Increase coverage for child life and flexible spending accounts
   - Decrease coverage for flexible spending accounts
10. Dependent No Longer Eligible
    - Drop coverage for your child, step-child or legal guardian
    - Waive coverage for child life and flexible spending accounts
    - Increase coverage for flexible spending accounts
    - Decrease coverage for flexible spending accounts and health savings account
11. Death of Child
    - Add coverage for child or step-child
    - Drop coverage for child, or step-child
    - Waive coverage for additional life, additional AD&D, spouse life, child life, group life, and flexible spending accounts
    - Increase coverage for additional life, additional AD&D, spouse life, child life, and flexible spending accounts
    - Decrease coverage for additional life, additional AD&D, spouse life, child life, and flexible spending accounts

- Increase coverage for flexible spending accounts
- Decrease coverage for flexible spending accounts

12. Add or Remove Court-Ordered Dependent
    - Add coverage for your court-ordered dependent
    - Drop coverage for your court-ordered dependent
    - Can change plan options for medical and dental
    - Elect coverage for yourself and your dependents, if you currently waived coverage (except STD)
    - Increase coverage for health savings account, health savings account catch-up, additional life, additional AD&D, spouse life, child life, and flexible spending accounts
    - Decrease coverage for health savings account, health savings account catch-up, additional life, additional AD&D, spouse life, child life, and flexible spending accounts
    - Increase coverage level for additional AD&D
    - Decrease coverage level for additional AD&D
13. Change in After Tax Benefits
    - Elect coverage for additional life, additional AD&D, spouse life and child life
    - Waive coverage for additional life, additional AD&D, spouse life and child life
    - Increase coverage for additional life, additional AD&D, spouse life and child life
    - Decrease coverage for additional life, additional AD&D, spouse life and child life
    - Increase coverage level for additional AD&D
    - Decrease coverage level for additional AD&D
14. Change in Dependent Care Cost
    - Increase coverage for dependent care flexible spending account
    - Decrease coverage for dependent care flexible spending account
15. Beneficiary Information Update
    - Update demographic information
16. Change HSA Contribution
    - Elect coverage for HSA contribution
    - Waive coverage for HSA contribution
    - Increase coverage for HSA contribution
    - Decrease coverage for HSA contribution
17. Change HSA Catch-Up Contribution
    - Elect coverage for HSA catch-up contribution
    - Waive coverage for HSA catch-up contribution
    - Increase coverage for HSA catch-up contribution
    - Decrease coverage for HSA catch-up contribution

WHAT DOCUMENTATION IS REQUIRED FOR QUALIFIED STATUS CHANGES?

The Employee Benefits Division requires documentation of your qualified status change within 30 calendar days of the event in order to process your change request submitted on the Group Insurance Qualified Status Change form. Below is a list of acceptable documentation.

1. Divorce, legal separation, annulment or change in legal custody, that include a qualified medical child support order requiring accident or health coverage for an employee's child: Copy of first and last pages of the court order and any other pages relating to the order requiring coverage.
2. Change in status:
    a. Events that change an employee's legal marital status: Marriage or death certificate, divorce or other legal document or decree (first and last pages of the court order and any pages identifying the effective date of the event and the date on which the document was finalized);
    b. Events that change an employee's number of dependents: Birth certificate, court adoption documents (first and last pages of the court order and any pages identifying the effective date of the event and the date on which the document was finalized);

c. Changes in the employment status of the employee, the employee's spouse or the employee's dependent: Document from the employer verifying the change and the date of the change.

3. Dependent satisfies or ceases to satisfy eligibility requirements: School schedule for the current semester/quarter from the institution verifying full-time student status.
4. Significant cost or coverage changes: Documentation of the before and after coverage and/or costs and the effective date of such change.

Please notify the Employee Benefits Division within the 30 calendar day period following the event if documentation is not available due to an extenuating circumstance.

PRIVACY

HIPAA Privacy Notice

In accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Maricopa County, in its role as the administrator and/or sponsor of the Employee Benefit Plan, or in its role as the health plan makes available a notice setting forth its privacy practices through the EBC/Intranet *http://ebc.maricopa.gov/ehi* home page. This notice describes the potential uses and disclosures of Protected Health Information (PHI), the individual's rights and the plan's legal duties with respect to PHI. The privacy notice may be updated occasionally and such updates are communicated through *e*Nouncements*, accessible through the EBC.

Sharing of Your Protected Health Information

You and your dependents' protected health information (PHI) will be shared with specific benefit plan representatives and others for the purposes of your health care treatment, payment for that treatment and health care operations (as defined in the HIPAA of 1996, as amended) of Maricopa County and of the benefit plan vendors, as well as for other purposes allowed or required by law. When you submit your enrollment application, are defaulted to a benefit plan because you did not submit your enrollment application timely, make an open enrollment election (including passive elections) or qualified status change or continue with your current coverage, you are acknowledging and accepting that Maricopa County and your health care providers, which could include CIGNA, CIGNA Dental, Walgreens Health Initiatives (WHI), Magellan Health Services, Delta Dental, EDS, The Standard, Sedgwick CMS, EyeMed Vision Care, and Automatic Data Processing (ADP) may share medical and administrative information concerning you and your dependents. By participating in the benefit plans, you are releasing Maricopa County and Maricopa County's plan administrators, benefit managers and vendors from any liability for any good faith release of PHI pursuant to this acknowledgement.

Employee Certification

By submitting your benefit elections, participating in open enrollment (including passive enrollments) or by allowing your benefits to be defaulted for coverage, you are authorizing Maricopa County to take deductions from your paycheck and from any short-term disability payments you may receive, to pay for benefit costs.

Further, you are authorizing Maricopa County to take additional deductions from your paycheck and/or any short-term disability you may receive to reimburse Maricopa County for any benefits you and/or your dependents were unauthorized or ineligible to receive because you provided inaccurate, incorrect and/or incomplete information to Maricopa County. Deductions to reimburse Maricopa County will be in accordance with the law. You are also authorizing the Employee Health Initiatives Division to send necessary personal information to your selected vendors to initiate and support your coverage.

Notice Regarding Use of Your Social Security Number or Health Insurance Claim Number

Disclosure of your Social Security Number (SSN) or your health insurance claim number (if enrolled in Medicare) for purposes of enrollment and other benefit-related uses is voluntary except when required under Section 111 of Public Law 100-173. Identification (ID) cards from all vendors will carry either a) no ID number, b) an edited ID number (revealing only the last four digits of your SSN), c) your employee ID number, or d) a randomly system-generated number. Your SSN is transmitted to the benefit plan vendors for administrative purposes. Some vendors will use your SSN as your ID number or cross-reference their assigned ID number to your SSN. If you do not want your SSN transmitted to the benefit plan vendors, you may request an alternative ID number. If you are participating in the flexible spending account plan or group legal plan, the vendor requires your SSN. If you enroll in the group legal plan, MetLaw, the vendor requires your social security number. If you do not want your SSN sent to the flexible spending account or group legal plan vendor, you should not enroll in these voluntary benefits.

Alternative ID Number

You may request an alternative ID number to be used in lieu of using your SSN at any time by completing the Alternative ID Request form available on the Employee Benefits Home page, or by sending your request in writing to the Employee Benefits Division. You will be provided with a form to complete before the alternative number can be assigned.

If you are completing your initial enrollment in benefits and you do not want your SSN sent to the vendors, you should not complete your enrollment online. Notify the Employee Benefits Division before the end of your enrollment period for assistance. Your enrollment (but not your benefit beginning coverage date) in benefits will be delayed until the alternative number is assigned.

Once assigned, the Employee Benefits Division will provide you your alternative ID number and notify your medical, pharmacy, vision, behavioral health and dental vendors. Once the vendor associates your enrollment with an alternative ID number, you and your dependents will not be identifiable by your SSN. You are responsible for advising each provider that you have an alternative ID number.

You should be aware of the following possible consequences of having an alternate ID number assigned:

- If the vendor uses a system-generated ID number, your alternative ID number will be cross-referenced to the system-generated ID number. When you access services, your provider will verify your current eligibility by calling the vendor. The provider must use either your current alternative ID number or your system-generated ID number so that your eligibility can be established, you can access services and your claims can be processed and paid.
- Additionally, when an alternative ID number is assigned, if you have ever been identified by your SSN, some vendors do not have the technology to cross-reference your records to re-establish prior authorizations or referrals for your care or to process claims submitted under your SSN because the key link between you and their records (your SSN) has been broken. This may cause a temporary delay in receipt of services or result in denied claims until you notify the vendor to correct the records

WELLNESS INITIATIVES AND INCENTIVES

Maricopa County values the health and well being of our employees. That's why we continue to improve our employee worksite wellness program by offering the following health and wellness initiatives and incentives that have been developed for our population based on biometric screening and health assessment results, as well as utilization trends.

We encourage you to participate in the initiatives and incentives for which you qualify in order to learn how you can take more control of your health and well being. If you would like additional information regarding the information below, call the Employee Benefits Division or go the Employee Benefits Home page and click on the Wellness tab. Wellness initiatives are communicated by *e*Nouncements* via the EBC. Please check with your department for its policy on attending wellness initiatives and programs during your scheduled work hours.

Initiative	***Description***	***Who is Eligible?***	***How to Access Services/Incentives***	***Cost/Incentive***
24-Hour Health Information Line	A telephonic health information library where you can listen to pre-recorded information on over a hundred health topics. Or, speak to a nurse for answers to your questions, suggestions for helpful home care, or assessment of symptoms and direction to the most appropriate care	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Call 800-244-6224 and listen for the prompt for the 24-hour Health Information Line or call 800-564-8982 for nurse assistance. To access the list of health information topics, go to *www.mycigna.com*, click on the "My Health" tab at the top of the page, find the "Health Management Resources" heading, then click on the "Health Information Line" link for more information about calling for live support or options to listen to a podcast.	No Cost
Adult Immunizations	Flu (by CIGNA and WHI) Pneumonia (by WHI) Tdap (Tetanus, Diphtheria & Pertussis) (by CIGNA)	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan for CIGNA Flu shots; Employees and their dependents enrolled in a WHI-pharmacy plan for WHI Flu and pneumonia shots; Employees enrolled in a County-sponsored CIGNA medical plan for Tdap; Note: must meet CDC guidelines for age, frequency and risk factors.	No appointment required for CIGNA worksite flu shot clinics; service is provided on a first come, first served basis. Appointment required via online WHI appointment scheduler for WHI worksite flu and pneumonia shot clinics. Employees and dependents may receive flu shots at CIGNA Flu Shot Clinics on a first come, first served basis. Employees and dependents may receive flu shots at Walgreens pharmacies on a first come, first served basis with a WHI voucher which is mailed to your home address.	Cost varies by service and place of the service; Generally, the onsite services are at no cost to the employee.

Please note, that wellness programs may be discontinued during the benefit plan year based on availability or funding for the program.

Initiative	*Description*	*Who is Eligible?*	*How to Access Services/Incentives*	*Cost/Incentive*
Am I Hungry?	An 8-week workshop that teaches you how to be in charge of your eating instead of feeling out of control; eat the foods you love without overeating and without guilt, and eat healthier foods without depriving or restricting yourself.	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll via Pathlore for class LIF160	No Cost
Biometric Screening	Voluntary, brief confidential personal health history, measurements of height, weight, waist circumference, body fat composition, non-fasting or fasting cholesterol and glucose levels (finger stick), and blood pressure. Based on the results of your Biometric Screening, a health coach, provided by Magellan Health Services, may call you to work with you one-on-one to help you identify and achieve your health and wellness goals. See "Health Coaching" initiative on this table. You'll receive a personalized results booklet at the end of your screening that a wellness coach will review with you. Take it to your next doctor's visit, or use it to ask your doctor questions to learn more about your health and to make simple changes to improve your health status.	Employees enrolled in a County-sponsored CIGNA medical plan	Screenings are performed by appointment only at several Maricopa County worksite locations and at selected CIGNA Medical Group facilities during the mass biometric screening event (generally March - May). Go online to *www.cignascreenings.com/maricopa* or call 800-694-4982 Monday - Friday 8 AM - 6 PM MST to schedule your appointment. Screenings are also performed once per month, for new hires or others missing the mass event, at the County Administration building at 301 W. Jefferson, Suite 160. Call 602-506-3758 to schedule an appointment. Screenings are also performed on a first come, first served basis at CareToday clinics throughout the year. *e*Nouncements* provide scheduling details during the mass event around the Open Enrollment period. Additional information is available on the Employee Benefits Home page or under the "Wellness" tab.	No Cost; You can save $5 per pay period up to a total of $120 annually per plan year**.** If you are newly eligible to receive the incentive, you must complete your screening within 30 calendar days of your medical benefit effective date for the incentive to be retroactive to such date. Otherwise, the incentive will be available on a prospective basis, the next pay period after completion. Screenings must be completed each year (starting in January and ending by the end date of Open Enrollment) in order to continue the incentive for the next plan year.
Blueprint for Wellness	30+ fasting lab tests, optional PSA for males over 40, optional fecal occult home test kit for employees over 50, mandatory online health risk assessment and a confidential personal wellness report.	Employees enrolled in a County-sponsored WHI pharmacy plan who have not participated in a Blueprint event in the last 6 months	By appointment only; scheduled online through Blueprint for Wellness	No Cost
Brush Biopsy	Early detection of oral cancer through a brush biopsy.	Employees and/or dependents enrolled in CIGNA Dental	Information available at *http://www.maricopa.gov/benefits/pdf/2008/CIGNA_Dental/cignadental_biopsy.pdf*	In-network: 20% co-insurance after deductible is met. Out-of-network: 40% co-insurance after deductible is met.

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Initiative	*Description*	*Who is Eligible?*	*How to Access Services/Incentives*	*Cost/Incentive*
Chronic Disease Self-Management Program	Educational program developed by Stanford University for employees with chronic conditions such as asthma, arthritis, diabetes, high blood pressure, low back pain or heart disease; 6-week course for 2 ½ hours per week.	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll through Pathlore on the EBC Intranet Look for class PED136B	No Cost; Receive a workbook, Living a Healthy Life with Chronic Conditions and an audio relaxation tape, Time for Healing
Colorectal Cancer Screening	Fecal Immunochemical (Insure Fit) at home test to detect blood in the stool, an early warning sign of colorectal cancer. Kit is mailed to your home.	Employees and spouses 50 and over (45 and over if African-American) enrolled in a WHI pharmacy plan.	Order online at *https://my.blueprintforwellness.com* through Oct. 14, 2009 Registration Key: maricopa Unique ID number: Use your 9-digit Maricopa County employee ID number for the employee; add an "s" to the end of your employee ID number for your spouse.	No Cost
Convenience Care Clinics (Take Care and Care Today Only)	Walgreens Take Care and CIGNA Care Today clinics, staffed by nurse practitioners or physician assistants, are located throughout the valley and provide treatment for acute, non-urgent and non-work-related injuries such as minor cuts, allergies, ear infections, sinusitis, strep throat, conjunctivitis, urinary tract infections; immunizations such as flu (seasonal), Tdap (tetanus, diphtheria & pertussis), pneumonia, flu, shingles, meningitis, mumps, measles and rubella, chicken pox, hepatitis A and B, gardasil, are also provided.	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Use the onsite Take Care clinic located on the 2nd floor of the County Administration building or find a Take Care clinic at *www.takecarehealth.com*. CIGNA Care Today locations are available at *www.cigna.com/cmgaz/index.html* Convenience Care clinics are open 7 days a week including evenings and most holidays. Service is offered on a first come, first served basis.	Receive a $10 discount off your normal PCP copay
Culprit and the Cure	6-week course focused on achieving and maintaining how to eat right and exercise, and set and achieve attainable goals.	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll via Pathlore on the EBC Intranet Look for class LIF114	No Cost; receive the Stop and Go book during class and Culprit and Cure book if you attend all 6 classes
Dental Cleanings	A third dental cleaning is available to employees and/or dependents who are pregnant or have diabetes.	Employees and/or dependents who are enrolled in Delta Dental.	Information available at *http://www.maricopa.gov/benefits/pdf/2008/Delta_Dental/third_cleaning.pdf*	No Cost

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Initiative	*Description*	*Who is Eligible?*	*How to Access Services/Incentives*	*Cost/Incentive*
Dental Oral Health Integration Program - Dental Oral Health Maternity Program℠	Since women with periodontal gum disease may be at increased risk for pre-term babies and that treatment for gum disease may reduce the likelihood of premature birth of women at risk, this program enhances dental benefits for expectant mothers. Eligible members may receive 100% reimbursement of copay or co-insurance for select covered services performed during pregnancy such as oral evaluation, periodontal scaling and root planing, periodontal maintenance, treatment of inflamed gums around wisdom teeth, and the frequency limitations for cleanings is waived to include an additional cleaning.	Employees and/or dependents who are enrolled in a County-sponsored CIGNA Dental and a CIGNA Medical plan.	Contact CIGNA. Information available at *http://www.maricopa.gov/benefits/pdf/2008/CIGNA_Dental/cignadental_oralhealth_mp.pdf*	No Cost
Dental Oral Health Integration Program - Oral Health Diabetes and Cardiovascular Programs	Research has linked periodontal (gum) disease to complications for heart disease, stroke and diabetes. This program provides employees and/or dependents with 100% reimbursement of their out-of-pocket payment to the dentist for: periodontal root scaling & planing and periodontal maintenance. Periodontal maintenance is increased to four times per year under the program.	Employees and/or dependents who are enrolled in a County-sponsored CIGNA Dental and Medical plan and who participate in the CIGNA WellAware Program for diabetes or heart disease.	Contact CIGNA Information available at *http://www.maricopa.gov/benefits/pdf/2008/CIGNA_Dental/cignadental_oralhealth_ip.pdf*	No Cost
Diabetes Management Program	Meet 9 conditions to participate; *Click here to review the brochure.*	Employees and their dependents diagnosed with diabetes who are enrolled in a County-sponsored WHI prescription plan	Enroll via the Employee Benefits Division	No Cost; Receive free diabetic medications and supplies for one year; annual recertification required for continued participation.
Diabetes Education	Appointment with a diabetes educator for assessment; Basic diabetes education class series; Continuing diabetes education class; and Intensive insulin management class.	Employees and their dependents who are enrolled in a County-sponsored CIGNA Medical plan.	At several CIGNA Medical Group facilities. See flyer on the Employee Benefits home page, under the Wellness tab. For general information call 623-876-2355.	Fee based classes

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Initiative	*Description*	*Who is Eligible?*	*How to Access Services/Incentives*	*Cost/Incentive*
Ergonomics Classes	Various classes taught by Ergonomic Specialists; Custom classes are available for locations with at least 10 participants.	All employees	Enroll via Pathlore on the EBC Internet.	No Cost
Ergonomics consult for seating, lighting, furniture, and equipment	Onsite evaluation of facility.	All employees	Go to Employee Benefits Web site and download the ergonomic request service form. Have your supervisor sign the form and fax to 602-506-8974. Some departments have ergonomic facilitators who handle all ergo requests.	No Cost
Ergonomics Evaluation	Evaluation at your individual workstation.	All employees	Go to Employee Benefits Web site and download the ergonomic request service form. Have your supervisor sign the form and fax to 602-506-8974. Some departments have ergonomic facilitators who handle all ergo requests.	No Cost
Fitness Center	Located in the basement of the County Administration building; locker rooms with showers, weights and cardio equipment	All employees	Complete enrollment form, located on the Employee Benefits Home page	No Cost
Health Coaching	Voluntary coaching program for employees with certain risks identified through the Biometric Screening Program and/or Health Assessment; help with developing a personal action plan, overcoming personal challenges, and staying motivated with one-on-one support and encouragement.	Employees who participated in the Biometric Screening Program and/or Health Assessment who have certain risk factors	Health Coach will contact you directly by phone	No Cost

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Initiative	*Description*	*Who is Eligible?*	*How to Access Services/Incentives*	*Cost/Incentive*
Health Assessment	Voluntary online questionnaire from the University of Michigan regarding your health and lifestyle. Confidential results are calculated and provide you with an assessment of your health status. The questionnaire asks information regarding biometric measures such as weight, blood pressure and cholesterol levels so it is advisable to take the assessment soon after participating in the Biometric Screening initiative. Based on your responses, you will also receive an invitation to participate in an online coaching program. Print a summary of your health report to take to your next doctor's visit, or use it to ask your doctor questions to learn more about your health and to make simple changes to improve your health status.	Employees enrolled in a County-sponsored CIGNA medical plan	Available online at *www.mycigna.com*; registration instructions and directions on how to access the health assessment tool are available on Employee Benefits Home page or under the "Wellness" tab.	No Cost; You can save $5 per pay period up to a total of $120 annually per plan year**.** If you are newly eligible to receive the incentive, you must complete your assessment within 30 calendar days of your medical benefit effective date for the incentive to be retroactive to such date. Otherwise, the incentive will be available on a prospective basis, the next pay period after completion. Assessments must be completed each year (starting in January and ending by the end date of Open Enrollment) in order to continue the incentive for the next plan year.
Healthful Living Diabetes Care Management Program	Educational program provided by a diabetic-certified pharmacist over a one-year period. The program is available through WHI and the Joslin Diabetes Center, the global leader in diabetes research, care and education, dedicated to improving health outcomes for people with diabetes. The role of the pharmacist is to review your medical history and medications to assess your diabetes control regimen and to recommend ways for you to better manage your condition.	Diabetic employees and/or dependents who are enrolled in a County-sponsored WHI prescription plan; participants can enroll and re-enroll annually for the program.	Call 866-202-4665 to enroll. Contact your health care provider and obtain a copy of your most recent lab tests for A1C, total cholesterol, HDL, LDL, and triglycerides to bring to your first appointment.	No Cost; Upon program completion, participants will be reimbursed for up to 9 diabetic-related office visit copays for one plan year.

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Initiative	*Description*	*Who is Eligible?*	*How to Access Services/Incentives*	*Cost/Incentive*
Healthy Pregnancies, Healthy Babies Program	Comprehensive maternity support program that provides education, assessment and a care plan.	Pregnant female employees enrolled in a County-sponsored CIGNA medical plan	Enroll by calling 800-244-6224 and ask to enroll in the Healthy Pregnancies, Healthy Babies Program	No Cost; $150 incentive available at program completion if enrolled in first trimester or $75 if enrolled in second trimester
Healthy Rewards	A discount program available through CIGNA that offers discounts on weight management and nutrition products and services; fitness equipment, clubs and programs; tobacco cessation program, alternative medicine services; mind/body programs; dental care; vitamins and health and wellness products.	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Information available via *www.cigna.com* Type in Healthy Rewards in the search box	Product and service costs and discounts are available on the CIGNA Web site
Lunch N Learns	Monthly classes on various health topics.	All employees	Registration requested through the Employee Benefits Division Walk-ins are allowed if space permits	No Cost
Mobile Onsite Mammography (MOM)	Mammography screening.	Annually for female employees at least 40 years of age enrolled in a County-sponsored CIGNA medical plan; other insurance also accepted	By appointment through MOM 480-967-3767 *www.mobileonsitemammography.com*	No Cost
Non-Smoker Reward for Additional Life Insurance	Non-smoking employees who have been smoke-free for at least 12 months receive a rate reduction on additional life insurance.	All benefit-eligible employees	If you have either never smoked or have not smoked for more than 12 consecutive months, you should review your coverage level options in the Benefit Enrollment System under the Additional Life page. The coverage level options listed below identify if you are eligible to receive the incentive for additional life insurance. ◦ Non-Tobacco User ◦ Tobacco User	Rate reduction for non-smokers when additional life insurance is purchased. Refer to life insurance rates in life insurance section.

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Initiative	*Description*	*Who is Eligible?*	*How to Access Services/Incentives*	*Cost/Incentive*
Non-Tobacco User Incentive	Non-tobacco using employees and their covered dependents who have been tobacco free for at least 6 months receive an incentive.	Employees enrolled in a County-sponsored CIGNA medical plan	Respond to the Non-Tobacco User Incentive options in the Benefit Enrollment System at time of enrollment. The options are listed below: ◦ I am a user of Tobacco products (default value in the system) ◦ I am not a Tobacco products user but a covered dependent is ◦ No one (employee & covered dependents(s)) uses Tobacco products The incentive is available only when the employee and all covered dependents do not and have not used tobacco products for at least 6 consecutive months. "Tobacco user" means the occasional or regular use of a tobacco product including, but not limited to, cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco. **Employees who do not provide accurate information and receive the incentive for which they are not eligible will be subject to disciplinary action up to and including termination.**	Save up to $480 per year ($20 per pay period) on your County-sponsored medical insurance premium. If you or a covered dependent were a user of tobacco and quit, you will be eligible for this incentive when you and all covered dependents in your household have been tobacco free for 6 consecutive months. Complete the Tobacco User Status form available on the Benefits Home page under General forms. Incentives are available on a prospective basis from the date the form is received in the Employee Benefits Division.
Nutritional Counseling	3 self-referral nutritional counseling visits with a registered dietician at designated CIGNA Medical Group facilities. Additionally, if enrolled in a CIGNA WellAware Disease management program, you can speak with a registered dietician 24/7 over the telephone.	Employees and their dependents who are enrolled in a County-sponsored CIGNA Medical plan.	Nutritional counseling is available at select CIGNA Medical Group facilities. Call 623-876-2555 for general information. If you are enrolled in the CIGNA WellAware program, call 800-249-6512 to speak with a registered dietician 24/7. If you are not enrolled in the WellAware program, call the number above to see if you qualify for enrollment.	For nutritional counseling visit, the PCP copay is charged per visit. No cost for telephonic WellAware consult.
Onsite Screenings	Blood pressure checks; Body composition evaluations; Strength test (dynamometer); Flexibility test (sit & reach); Sub-Max cardio test (3 minute step); Bone density; Sun damage awareness (Dermascan); Diabetic foot screening; and Spirometry.	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Enroll via the Employee Benefits Division	No Cost

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Initiative	*Description*	*Who is Eligible?*	*How to Access Services/Incentives*	*Cost/Incentive*
Onsite Pharmacy	Full service Walgreens retail pharmacy.	Benefit-eligible employees and dependents are eligible to use the onsite pharmacy	Located on the 2nd floor of the County Administration building. Open Monday - Friday, 7 AM - 5 PM. 602-283-9925 602-283-9934 (Fax)	WHI Consumer Choice Plan: members receive a $25 deposit into their Level 1 pharmacy account when they get their first prescription filled. Available once per lifetime and can only be used at the onsite pharmacy for prescriptions. WHI Co-insurance Plan: members save an additional 10% on generic medication and 5% on preferred brand medication when filling a 90-day prescription. This savings is realized when compared to the cost at another retail pharmacy but will not be realized if the member is paying the minimum copayment. Members paying the maximum copay of $36 for generic or $120 for preferred brand will save with the lower maximum of $28 for generic or $70 for preferred brand.
Prostate Onsite Project (POP)	Prostate Antigen Specific (PSA) blood test and digital rectal exam.	Annually for male employees at least 40 years of age enrolled in a County-sponsored CIGNA medical plan	By appointment through the Employee Benefits Division	No Cost
Smoke Free	One-on-one monthly telephonic health coaching sessions for six months with one follow-up call nine months after enrollment. Enrollees receive step-by-step quitting advice, health education and motivational materials including a workbook to help track their smoke-free progress.	Employees and their dependents age 18 and above enrolled in a WHI pharmacy plan	Call 866-661-6781 to enroll. Please mention you are registering for the WHI Smoke Free program offered by Maricopa County.	No Cost; OTC and prescription smoking cessation medications are covered 100% up to $500/plan year. Products are limited to a 30-day supply of smoking cessation product per coaching call.

Please note, that wellness programs may be discontinued during the benefit plan year based on availability or funding for the program.

Initiative	*Description*	*Who is Eligible?*	*How to Access Services/Incentives*	*Cost/Incentive*
Ultrasound Screening	Ultrasound screenings for osteoporosis/bone density, carotid artery, abdominal aortic aneurysm (AAA), peripheral arterial disease (PAD), thyroid, gall bladder, kidneys and liver.	All employees	By appointment through Health First by calling 800-209-4848	Any 3 tests - $115. Any 5 tests - $140 Any 8 tests - $160 Prices are subject to change without notice.
Work Life Balance	Classes offered through various mediums by Magellan Health Services.	All employees (for onsite classes); and employees enrolled in a County-sponsored CIGNA medial plan (for online classes or webinars)	Enroll through Pathlore for onsite classes and webinars. Go to *http://ebc.maricopa.gov/training*, click on the "On-line Learning Center" link. A new window will pop-up, click on "Schedule of Upcoming Classes", scroll down to "Employee Benefits" and click the "GO!" button.	No Cost
Waisting Away Incentive Program	Program offering a reward for losing weight when attending Weight Watcher (WW) classes.	Employees and their dependents age 10 and up enrolled in a County-sponsored CIGNA medical plan	Contact the Employee Benefits Division upon meeting program requirements. Must provide a copy of your paid receipt for the WW 10-week program along with a copy of the WW booklet showing attendance dates, and your beginning and ending weight	Attend 8 of 10 WW classes in a 10-week period and lose 10 pounds to receive $110 American Express Gift card
Weight-to-Go	8-week, 1½ hour class taught by a Registered Dietician. Includes 6-month follow-up class.	Employees enrolled in a County-sponsored CIGNA medical plan	By appointment through the Employee Benefits Division	No Cost
Weight Watchers at Work	10-week program that focuses on portion control, mindful eating and lifestyle changes.	All employees	Enroll through Weight Watchers 602-248-0303	$120 per each 10-week session. Costs may increase without notice.

Please note, that wellness programs may be discontinued during the benefit plan year based on availability or funding for the program.

Initiative	*Description*	*Who is Eligible?*	*How to Access Services/Incentives*	*Cost/Incentive*
Well Aware Disease Management Program	A Program that offers telephonic guidance and resources from a registered nurse for diseases and conditions such as asthma, diabetes, COPD, low back pain, weight complications, heart disease, fibromyalgia, acid-related disorders, atrial fibrillation, decubitus ulcer, hepatitis C, inflammatory bowel disease, irritable bowel syndrome, osteoarthritis, osteoporosis, and urinary incontinence.	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan with specific diseases or conditions	A Well Aware nurse will contact you directly or you may enroll by calling 866-797-5833	No Cost
Wellness Expo	Visit with health care vendors and receive information on health, benefits and ergonomics; participate in preventive screenings.	All employees	None	No Cost

Please note, that wellness programs may be discontinued during the benefit plan year based on availability or funding for the program.

MEDICAL PLANS

Administered by CIGNA

This section provides a brief summary of information on the different medical plans offered, how they operate and the cost of services and premiums. For more detailed information, please contact the CIGNA Pre-Enrollment or customer service phone number listed in the "Who to Contact" section. Choices include CMG (CIGNA Medical Group), a managed-care health maintenance organization (HMO) plan, Open Access Plus In-Network (OAPIN), an HMO plan with open access to specialists within the network, Open Access Plus (OAP), an HMO plan with open access to specialists both within the network and outside of the network, and a high deductible health plan, CIGNA Choice Fund, that comes with a Health Savings Account. Some plans have a high and a low option from which to choose. High options have higher premiums but lower copayments for services while low options have lower premiums but higher copayments for services.

If you enroll in a medical plan, you must review the Non-Tobacco User Incentive option in the Benefit Enrollment System and answer the question regarding the tobacco use status of yourself and any of your covered dependents. When you participate in this initiative, you receive an incentive of up to $480 per plan year that helps reduce the cost of your medical insurance premium. The questions are listed below:

- I am a user of Tobacco products
- I am not a Tobacco products user but a covered dependent is
- No one (employee & covered dependents(s)) uses Tobacco products

If you do not respond to this option, it will default to "I am a user of Tobacco products" and you will not receive the incentive.

"Tobacco User" means the occasional or regular use of a tobacco product including but not limited to cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco. Refer to the "Wellness Initiatives and Incentives" table above under "Non-Tobacco User Incentive" for details.

Additionally, enrollment in a medical plan requires you to respond to options in the Benefit Enrollment System regarding Biometric Screening and Health Assessment participation. These initiatives apply only to you, the employee, and not to your covered dependents.

When you participate in either or both initiatives, you receive an incentive of up to $120 per plan year per initiative that helps reduce the cost of your medical insurance premium. If you do not respond to these options, they will default to a non-participation status and you will not receive the incentive. Refer to the "Wellness Initiatives and Incentives" table above under "Biometric Screening" and "Health Assessment" for details.

Employees who do not provide accurate information and receive incentives for which they are not eligible will be subject to disciplinary action up to and including termination. Additionally, providing inaccurate information regarding tobacco use may result in the life insurance company rescinding life insurance coverage.

All medical plans include the following, except as noted

24-hour worldwide emergency care.

24-hour Health Information Line[sm]: Provides access to health information from Registered Nurses at any time. When you are not sure where to go to seek non-emergency care, you can call and speak with a nurse who can respond to your health care questions, direct you to the nearest participating medical facility or provide suggestions for helpful home care that may comfort you until you can see your doctor. Call 800-244-6224 and listen for the prompt for the 24-hour Health Information Line or call 800-564-8982. You also have access to the Health Information Library where you can listen to taped programs on hundreds of topics. Refer to the "Wellness Initiatives and Incentives" section for information on how to access the list of topics.

Alternative Medicine Benefit: Twenty self-referred alternative medicine visits per plan year are covered. Copayments vary depending on the medical plan selected. A $60 credit for herbal/homeopathic or natural supplies dispensed in conjunction with an office visit is also covered. Providers in CIGNA's designated alternative medicine network must be used when accessing this benefit. This benefit is not available out-of-network. Refer to the "Alternative Medicine Information" flyer available on the Employee Benefits Home page under the CIGNA tab and then under the "Other Forms and Documents" heading.

Covered services are:

- Physician evaluation and management
- Physical medicine
- Acupuncture/acupressure
- Massage therapy
- Homeopathic consultation
- Biofeedback/guided imagery

Behavioral Health/Substance Abuse Benefit: Provided by Magellan Health Services (except for CIGNA Choice Fund medical plan for which behavioral health/substance abuse benefits are provided by CIGNA Behavioral Health). Refer to the "Behavioral Health and Substance Abuse" section for benefit details.

Case Management: Case management involves you (or your dependents) with specific complex health care needs, such as oncology, burns, heart disease complications and high-risk pregnancies, for which a treatment plan is formulated and implemented by CIGNA to improve your health status. If you choose to disenroll or not participate in Case Management, you will be charged an additional $250 for related services.

CIGNA Care Network Specialist Discount: When selecting in-network specialty care through a CIGNA Care Network (CCN) provider, the office visit is offered at a $15 lower copayment for all medical plans (except the Choice Fund Health Savings account plan). The CIGNA Care Network is a high-performing cost-effective specialty network that meets certain criteria related to quality and efficiency. Refer to the Glossary of Terms section to see which specialties participate in the CCN network. CCN providers are identified in the CIGNA online provider directory at www.cigna.com by a Tree of Life symbol.

Guesting Privileges: Provides access to in-network benefits while your dependents are temporarily absent from the service area. Call the CIGNA Customer Service Department to determine whether your dependent qualifies to participate. Certain restrictions apply.

Healthy Rewards Program: Discounts on alternative health services and health and wellness products such as fitness club memberships, chiropractic services, therapeutic massage, acupuncture, cosmetic dentistry, laser vision correction, vitamins and herbal supplements, and hearing aids and tests. Call 800-870-3470 to find out more information or go online to *www.cigna.com/healthyrewards*.

myCIGNA.com: Access your benefit and claim information, request an ID card, view your provider directory, change your PCP and more through this secure online Web site.

Pharmacy Benefit: Provided by Walgreens Health Initiatives (except for CIGNA Choice Fund medical plan for which the pharmacy benefit is provided by CIGNA). You will select your pharmacy benefit separately from your medical plan. Refer to the "Pharmacy Benefit" section for plan choices and benefit details.

Urgent Care: Urgent care situations require prompt medical attention, but are not emergencies. If you go to urgent care seeking medical treatment and the urgent care provider directly refers you to the emergency room, your urgent care copay will be reimbursed once CIGNA processes the emergency room claim. It may take up to 30 working days to receive reimbursement from CIGNA for your urgent care copay. If you have questions regarding your reimbursement please call CIGNA customer service. Urgent care locations can be viewed at *http://www.maricopa.gov/benefits/pdf/2009/CIGNA/urgent_care_listing.pdf*.

Vision Benefit: Provided by EyeMed Vision Care. See the "Vision Benefit Plan" section for benefit details.

Wellness Programs: Well Aware for Better Health is an integrated disease management program helping CIGNA members manage asthma, low back pain, cardiovascular disease, diabetes, chronic obstructive pulmonary disease, weight complications, and targeted conditions such as fibromyalgia, hepatitis C, irritable bowel syndrome, acid-related disorders, atrial fibrillation (irregular or fast heartbeat), decubitus ulcer (pressure or bed sore), inflammatory bowel disease, osteoarthritis, osteoporosis and urinary incontinence. To see if you qualify, call 800-249-6512. Once you are enrolled in a disease management program, you can contact a nurse or dietician for consultation at 877-888-3091. Healthy Pregnancies, Healthy Babies is another wellness program for prenatal guidance, available by calling 800-244-6224. An incentive is available when you complete the program. If you enroll in the first trimester you will receive $150, or $75 for second trimester enrollment. Additional wellness programs are available to employees enrolled in County medical plans. Please refer to the "Wellness Initiatives and Incentives" section for further information.

CIGNA Administers the Medical Plan

If you have questions regarding covered benefits, claims payment, the appeal process or a provider's participation status, contact CIGNA Customer Service Department, 24 hours per day, 7 days per week. See the "Who to Contact" section at the end of this booklet for details. Additional resources that are available are CIGNA's Web sites *www.cigna.com*, *www.mycigna.com*, and *www.mycignaplans.com*.

Medical claims are mailed to:

CIGNA

P.O. Box 182223

Chattanooga, TN 37422-7223

CHOOSING THE PLAN THAT SUITS YOU

Maricopa County is committed to promoting better health for its employees and their families by continually evaluating our employee health benefits. Furthermore, Maricopa County continually looks for innovative solutions that will help all of us effectively control short and long-term health care costs without sacrificing the quality of health care you and your family deserve. We believe that by providing a wide selection of medical insurance benefit options every employee has the opportunity to choose the "right plan" for their family.

To help you decide what medical plan is "right for you", please consider the following questions in the tables below. Table A is specific to the High Deductible Health Plan (HDHP) with the Health Savings Account, and Table B applies to all other medical options. Please take the time to review both tables and the plans for which you are interested.

TABLE A - IS THE CHOICE FUND HEALTH SAVINGS ACCOUNT BENEFIT OPTION RIGHT FOR YOU?	
Do you consider yourself to be healthy?	Yes / No
Do you enjoy managing and investing your money in programs like Deferred Compensation or other investments vehicles and watching the balance grow over the years?	Yes / No
Are you interested in having funding available to help save for future medical and retiree health expenses on a tax-free basis?	Yes / No

If you answered Yes more than twice, please turn to the Medical Plan Summary Chart for more information on the CIGNA Choice Fund HSA plan benefit option.

TABLE B - FIND THE MEDICAL PLAN THAT'S BEST FOR YOU!	
Question / Answer	**Applicable Plans**
Q: Will you and/or your covered dependents live outside of Maricopa County during the plan year? A: The OAP High and Low options as well as Choice Fund HSA offer out-of-network benefits and national networks of providers. The OAP In-Network option uses a national network of providers.	OAPIN OAP High OAP Low Choice Fund HSA
Q: Do you like to use the CIGNA Medical Centers exclusively for your primary care needs? A: If you enjoy the convenience of receiving your primary medical care through a CIGNA Medical Center (owned and operated by CIGNA), you may want to consider the CMG High or Low benefit options.	CMG High CMG Low
Q: Do you prefer lower out-of-pocket costs (copays and co-insurance) when deciding which medical benefit option to choose? A: Lower out-of-pocket costs, such as copays, mean that your per paycheck deduction will be higher. CMG High and OAP In-network benefit options offer lower copays.	CMG High OAPIN
Q: Are your doctors and hospitals covered under the medical benefit option you choose? A: For all benefit options, CIGNA contracts with a variety of medical providers for different services that includes doctors, hospitals, laboratories, etc. Some benefit options offer larger networks that includes private practice primary care physicians and national networks to cover out-of-area services. The OAP In-network, OAP Low, OAP High and CIGNA Choice Fund HSA benefit options offer large provider networks.	OAP Low OAP High OAPIN Choice Fund HSA
Q: Do you like having the flexibility of seeing providers who are outside of the plan's network? A: The OAP Low, OAP High and Choice Fund HSA benefit options offer coverage of providers who are not in the plan's network.	OAP High OAP Low Choice Fund HSA
Q: Is having direct access to network providers without a referral important to you? A: For the OAP In-Network, OAP Low, OAP High and Choice Fund HSA benefit options, NO referrals to network specialists or PCP designation is necessary.	OAPIN OAP High OAP Low Choice Fund HSA

Find out how the plans work and compare plans to determine which plan works best for you. Log on to ***www.mycignaplans.com*** between May 4, 2009 through June 30, 2010 using **Open Enrollment ID:** *Maricopa2009* and **Open Enrollment password:** *cigna*

QUESTIONS?

Refer to the "Who to Contact" section at the end of this booklet.

MEDICAL PLAN SUMMARY CHART

Benefit Provision	CIGNA Medical Group High (CMG High):		CIGNA Medical Group Low (CMG Low):		Open Access Plus In-Network (OAPIN):	
Type of Plan	***HMO***		***HMO***		***HMO*** with Open Access to Specialists	
Service Area Where Care Must be Received	Maricopa County only, except for emergency care		Maricopa County only, except for emergency care		Nationally	
Residency Requirement	Must work or reside in Maricopa County		Must work or reside in Maricopa County		None	
Primary Care Physician (PCP) Required	Yes; May only use PCP's who practice in CIGNA Medical Group Centers		Yes; May only use PCP's who practice in CIGNA Medical Group Centers		No	
Referral Required	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine		Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine		No	
Out-of-Network Coverage	No		No		No	
Network	AZ-CIGNA Medical Group Network AZ812		AZ-CIGNA Medical Group Network AZ812		National Open Access Plus AZ300	
Prior Authorization	Provider's responsibility		Provider's responsibility		Provider's responsibility	
Per Pay Period (24/yr.) Medical Premiums**	**Full-time**	**Part-time**	**Full-time**	**Part-time**	**Full-time**	**Part-time**
Employee	$36.68	$125.49	$34.34	$89.68	$45.79	$143.37
Employee + Spouse	$55.03	$136.65	$47.12	$100.70	$102.93	$156.39
Employee + Child(ren)	$43.74	$133.39	$39.36	$98.24	$82.03	$152.89
Employee + Family	$73.24	$141.31	$59.16	$102.63	$138.16	$161.97

**The premium will be reduced by $20 if the entire household (employee and all covered dependents) is tobacco-free for the past six consecutive months; and/or by $5 for voluntarily participating in the biometric screening initiative; and/or by $5 for voluntarily participating in the health assessment initiative.

Find out how the plans work and compare plans to determine which plan works best for you. Log on to ***www.mycignaplans.com*** between May 4, 2009 through June 30, 2010 using **Open Enrollment ID:** *Maricopa2009* and **Open Enrollment password:** *cigna*

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

MEDICAL PLAN SUMMARY CHART

Benefit Provision	Open Access Plus High (OAP High):		Open Access Plus Low (OAP Low):		Choice Fund-HSA[1]:	
Type of Plan	***HMO*** with Open Access to Specialists		***HMO*** with Open Access to Specialists		***High-deductible PPO*** plan with partially funded Health Savings Account[1]	
Service Area Where Care Must be Received	Nationally		Nationally		Nationally	
Residency Requirement	None		None		None	
PCP Required	No		No		No	
Referral Required	No		No		No	
Out-of-Network Coverage	Yes		Yes		Yes	
Network	National Open Access AZ300		National Open Access AZ300		National Preferred Provider Network AZ011	
Prior Authorization	Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.		Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.		Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.	
Per Pay Period (24/yr.) Medical Premiums**	**Full-time**	**Part-time**	**Full-time**	**Part-time**	**Full-time**	**Part-time**
Employee	$46.73	$148.76	$34.62	$95.13	$30.00	$131.47
Employee + Spouse	$103.87	$163.12	$47.76	$102.12	$30.00	$147.23
Employee + Child(ren)	$82.90	$159.12	$39.68	$100.24	$30.00	$141.39
Employee + Family	$139.65	$169.95	$60.46	$104.50	$30.00	$156.95

**The premium will be reduced by $20 if the entire household (employee and all covered dependents) is tobacco-free for the past six consecutive months; and/or by $5 for voluntarily participating in the biometric screening initiative; and/or by $5 for voluntarily participating in the health assessment initiative.

[1] Employee and covered dependents cannot be enrolled in any other type of medical insurance to qualify. Maricopa County contributes $500 for employee only coverage or $1,000 for employee and dependent coverage to your HSA pro-rated by the number of months remaining in the plan year. You can contribute up to $3,000 for 2009 and $3,050 for 2010 (individual) or $5,950 for 2009 and $6,150 for 2010 (family) to your HSA, plus $1,000 catch-up if over 55. Unused balances roll over.

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MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		CIGNA Medical Group High (CMG High)	CIGNA Medical Group Low (CMG Low)	Open Access Plus In-Network (OAPIN)
		In-Network Coverage Only		
Deductible (Only applies to inpatient and outpatient hospital facilities except for Choice Fund HSA)	Individual	$100	$300	$100
	Family	$200	$600	$200
Standard Percent of Co-insurance		N/A	90%	N/A
Out-of-Pocket Maximum (Refer to the Summary Plan document for details)	Individual	$1,000	$5,000	$1,000
	Family	$2,000	$10,000	$2,000
Pre-existing Condition Limitation		None	None	Yes, same as for OAP High & Low Options
Preventive Care		$0 (FREE)	$0 (FREE)	$0 (FREE)
Primary Care Physician Services[1]		$15	$25	$20
Convenience Care Clinic Visit (only applies to Take Care and Care Today Clinics)		$5	$15	$10
Specialty Care Physician Services		$25* / $40	$45* / $60	$30* / $45
Advanced Radiological Imaging: CT, PET, MRI, MRA Scans/type of scan/day and nuclear cardiac studies**		$50	$100	$100
Allergy Injections		$8* / $23	$13* / $28	$10* / $25
Outpatient Lab and X-ray at free-standing facility		$0	$0	$0
Inpatient Hospital Facility Charges		Deductible and $100/admit	Deductible, $500/admit, then 10%	Deductible and $200/admit
Inpatient Physician and Surgeon's Services		$0	$0	$0
Outpatient Hospital Facility Services		Deductible and $100 copay	Deductible, $250 copay, then 10%	Deductible and $100 copay
Pre- & Postnatal Exams (after pregnancy has been determined)		$25* / $40, waived after 1st visit	$45* / $60, waived after 1st visit	$30* / $45, waived after 1st visit
Delivery - Inpatient Hospital Charge		Deductible and $100/admit	Deductible, $500/admit, then 10%	Deductible and $200/admit
Urgent Care (Copay reimbursed if referred directly to Emergency Room)		$75, waive if admitted to hospital	$75, waive if admitted to hospital	$75, waive if admitted to hospital
Emergency Room		$150, waived if admitted	$150, waived if admitted	$150, waived if admitted
Ambulance		$0	$0	$0
Durable Medical Equipment No annual limit (copay applies to each item)		$75	$75	$75
External Prosthetics		$0	$0	$0
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 120 visits maximum combined/yr. except as noted		$25/provider per day***	$45/provider per day***	$30/provider per day
Cardiac Rehab; 36 visits/yr.		$25 per visit	$45 per visit	$30 per visit
Alternative Medicine; 20 visits/yr. $60 credit for supplies/products		$15 per visit	$25 per visit	$20 per visit
Behavioral Health/Pharmacy		Magellan/WHI		

For more detail, review the medical plan summaries on the Employee Benefits Home Page or go to ***www.mycignaplans.com*** to compare plans.

*CIGNA Care Network Specialist, for more information see the Glossary of Terms and the "Medical Plans" section.

**Advanced radiology copays apply in addition to inpatient, outpatient and emergency room copays or co-insurance.

***Chiropractic visits have a separate 60 visit limit per plan year. Other therapies have a combined 60 visit limit per plan year.

[1]A limited number of primary care physicians are contracted with CIGNA as specialists. In this case the applicable CCN or non-CCN specialist copay applies.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Open Access Plus High (OAP High)		Open Access Plus Low (OAP Low)		Choice Fund-HSA:	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
$100	$500	$300	$1,000	$1,200 (cross accumulated)	$1,200 (cross accumulated)
$200	$1,000	$600	$2,000	$2,400 (cross accumulated)	$2,400 (cross accumulated)
N/A	70% of reasonable & customary	90%	70% of reasonable & customary	90%	70% of reasonable & customary
$1,500	$3,000	$5,000	$10,000	$2,000 (cross accumulated)	$2,000 (cross accumulated)
$3,000	$6,000	$10,000	$20,000	$4,000 (cross accumulated)	$4,000 (cross accumulated)
12 months for treatment in prior 60 days. Waived with certificate of creditable coverage and for employees currently covered by a county medical plan for at least 12 months. Certificate of creditable coverage must be sent to CIGNA and also provided to the Employee Benefits Division.					
$0 (FREE)	Covered in-network only	$0 (FREE)	Covered in-network only	$0 (FREE)	Covered in-network only
$25	30% after deductible	$35	30% after deductible	10% after deductible	30% after deductible
$15	30% after deductible	$25	30% after deductible	10% after deductible	10% after deductible
$35* / $50	30% after deductible	$50* / $65	30% after deductible	10% after deductible	30% after deductible
$100	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
$13* / $28	30% after deductible	$18* / $33	30% after deductible	10% after deductible	30% after deductible
$0	30% after deductible	10%	30% after deductible	10% after deductible; $0, no deductible if preventive	30% after deductible
Deductible and $250/admit	30% after deductible	Deductible, $1,000/admit, then 10%	Deductible, $2,000/admit, then 30%	10% after deductible	30% after deductible
$0	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
Deductible and $100 copay	30% after deductible	Deductible, $500 copay, then 10%	Deductible, $1,000 copay, then 30%	10% after deductible	30% after deductible
$35* / $50, waived after 1st visit	30% after deductible	$50* / $65, then 10%	30% after deductible	10% after deductible	30% after deductible
Deductible and $250/admit	30% after deductible	Deductible, $1,000/admit, then 10%	Deductible, $2,000/admit, then 30%	10% after deductible	30% after deductible
$75, waive if admitted to hospital	$75, waive if admitted to hospital	$75, waive if admitted to hospital	$75, waive if admitted to hospital	10% after deductible	10% after deductible
$150, waived if admitted	$150, waived if admitted	$150, waived if admitted	$150, waived if admitted	10% after deductible	10% after deductible
$0	$0	10%	10%	10% after deductible	10% after deductible
$75	30% after deductible	$75 and 10%	30% after deductible	10% after deductible	30% after deductible
$0	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
$35/provider per day	30% after deductible/provider per day	$50/provider per day	30% after deductible/provider per day	10% after deductible/provider per day	30% after deductible/provider per day
$35 per visit	30% after deductible	$35 per visit	30% after deductible	10% after deductible	30% after deductible
$25 per visit	Covered in-network only	$35 per visit	Covered in-network only	$15 per visit	Covered in-network only
Magellan/WHI				CIGNA Behavioral Health/CIGNA Pharmacy	

For more detail, review the medical plan summaries on the Employee Benefits Home Page or go to ***www.mycignaplans.com*** to compare plans.

*CIGNA Care Network Specialist, for more information see the Glossary of Terms and the "Medical Plans" section.

**Advanced radiology copays apply in addition to inpatient, outpatient and emergency room copays or co-insurance.

***Chiropractic visits have a separate 60 visit limit per plan year. Other therapies have a combined 60 visit limit per plan year.

[1]A limited number of primary care physicians are contracted with CIGNA as specialists. In this case the applicable CCN or non-CCN specialist copay applies.

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PHARMACY PLANS
ADMINISTERED BY WALGREENS HEALTH INITIATIVES

RX BIN#603286/RX PCN# 01410000

If you (and your dependents) enroll in a County-sponsored medical plan, except for the Choice Fund HSA plan, you (and your dependents) must enroll in one of the pharmacy plans below.

Co-insurance Benefit Plan

The Co-insurance benefit is a five-level plan in which a co-insurance amount (percentage of the cost[1]) of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication per the Preferred Medication List. This list is available on the Employee Benefits Home page. This plan covers generic, preferred brand-name, non-preferred brand-name and specialty medication. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, oral non-sedating antihistamines, erectile dysfunction, non-steroidal anti-inflammatory and cosmetic medications, are excluded. You are responsible for paying 100% for the cost[1] for excluded medications.

You will be charged the minimum or maximum copay or the co-insurance amount for the medication, based on the medication's level and cost. If you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost between the generic and non-preferred brand-name medications.

The co-insurance or the minimum or maximum copay you pay toward any covered medication applies to your out-of-pocket maximum except when a non-preferred brand name medication with a generic equivalent is purchased, the difference between the brand and the generic equivalent will not count. The out-of-pocket limit is $1,500 for an individual and $3,000 for a family[2]. Once the out-of-pocket limit is met, covered medications are paid 100% by the plan for the remainder of the plan year, except for the difference between the non-preferred brand and its generic equivalent, which will continue to be your responsibility.

Annual Out-of-Pocket Maximum $1,500 Single / $3,000 Family[2]				
	Classification	**Up to 30-Day Supply**		
Level 1	Generic	$2 Minimum	25% Co-insurance[1]	$12 Maximum[3]
Level 2	Preferred Brand	$5 Minimum	30% Co-insurance[1]	$40 Maximum[3]
Level 3	Non-Preferred Brand with Generic equivalent	$40 Minimum	50% Co-insurance[1] +	Difference between NP brand & generic cost
Level 4	Non-Preferred Brand with No Generic equivalent	$40 Minimum	50% Co-insurance[1]	
Level 5	Non-Preferred Brand Specialty Drugs	$50 Copay		

Per Pay Period (24/yr.) Pharmacy Premiums	**Full-Time**	**Part-Time**
Employee	$5.35	$14.36
Employee+Spouse	$10.59	$20.40
Employee+Child(ren)	$7.96	$17.61
Employee+Family	$15.89	$25.96

[1] Cost of medication is calculated by average wholesale price minus discount percentage or maximum allowable cost plus dispensing fee. Discount amount varies by place of service and number of days supplied. To find the lowest cost for medication between retail, Advantage90™ and mail service, go to *www.mywhi.com*.
[2] Family refers to employee and one or more covered dependents.
[3] Maximums are reduced when mail service is used.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

Contact Walgreens Health Initiatives (refer to "Who to Contact" section) for additional information, or view the detailed *Pharmacy Summary Plan* document available on the Intranet Employee Benefits site at *ebc.maricopa.gov/ehi*.

Consumer Choice Benefit Plan

The Consumer Choice Plan has four levels of coverage:

- Level 1 is a County-funded pharmacy account. The County will place $300 in an Individual account or $500 in a Family account (family in this case is defined as more than 1 person covered). In terms of Family coverage, the $500 is available to whichever family members use the pharmacy benefit on a first come, first served basis.
- Level 2 consists of the Employee deductible portion and begins when the $300 Individual or $500 Family amount in Level 1 is exhausted. Employees must meet their $300 or $500 deductible before moving to the next level.
- Level 3 is traditional insurance coverage where the County pays 80% of the cost and you pay the remaining 20% for the remainder of the plan year.
- Level 4 is limited to specialty medications only for which a $50 copayment is charged. Specialty medication copayments do not apply to Levels 1 - 3.

For further clarification on the Consumer Choice Pharmacy Plan, refer to the Pharmacy Benefit Plan booklet found on the Employee Benefits Home page.

The Consumer Choice benefit is geared towards smart spending through the use of the most cost-effective medication. A preferred medication list (PML) is not used to manage this benefit because much of the management is up to you. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, oral non-sedating antihistamines, erectile dysfunction, non-steroidal anti-inflammatory and cosmetic medications, are excluded. You are responsible for paying 100% of the cost[1] for excluded medications.

The amounts you pay toward any covered medication will apply to your plan year out-of-pocket maximum. The out-of-pocket maximum is $1,500 for individual coverage or $3,000 for family[2] coverage. Once the out-of-pocket maximum is met, covered prescriptions are paid 100% by the plan for the remainder of the plan year.

Annual Out-of-Pocket Maximum $1,500 Single / $3,000 Family[2]					
	Certain generic preventive medications are provided at no cost and are not charged or credited against any Levels. List available on the Employee Benefits Home page.				
Level 1	Pharmacy Account	Individual Family[2]	$300 Individual $500 Family	100% Employer paid[1]	Any unused amount is rolled over to next plan year
Level 2	Employee Deductible	Individual Family[2]	$300 Individual $500 Family	100% Employee paid[1]	
Level 3	Traditional Insurance Coverage			20%[1] covered by Employee	80%[1] covered by Employer
Level 4	Specialty Drug	$50 copay; does not apply to Levels 1 - 3; rollover amount is not available for specialty drugs. Copay applies to out-of-pocket maximum.			

Per Pay Period (24/yr.) Pharmacy Premiums	**Full-Time**	**Part-Time**
Employee	$0.00	$9.17
Employee+Spouse	$0.00	$10.10
Employee+Child(ren)	$0.00	$9.88
Employee+Family	$0.00	$10.50

[1] Cost of medication is calculated by average wholesale price minus discount or maximum allowable cost plus dispensing fee. Discount amount varies by place of service and number of days supplied. To find the lowest cost for medication between retail, Advantage90™ and mail service, go to *www.mywhi.com*.

[2] Family refers to employee and one or more covered dependents.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

Contact Walgreens Health Initiatives (refer to "Who to Contact" section) for additional information, or view the detailed *Pharmacy Summary Plan* document available on the Intranet Employee Benefits site at *ebc.maricopa.gov/ehi*.

Walgreens Health Initiatives

Did you know?
Diabetic medications & supplies are free & up to 9 office visit copays can reimbursed with either WHI plan if you participate in the Diabetic Management Programs!
Call 602-506-1010 to enroll.

Co-insurance & Consumer Choice Benefit Plans

THREE-MONTH SUPPLY AT CERTAIN RETAIL PHARMACIES – ADVANTAGE90™ When you need maintenance medications for chronic or long-term health conditions, you must purchase a three-month supply at any pharmacy located in a retail pharmacy participating in Advantage90™ or through mail service, after two fills of 30 or less days supply of a maintenance medication at a retail pharmacy. The physician must write your prescription for an 84-91 day supply. Refer to *www.mywhi.com* for a list of pharmacies participating in Advantage90™. Your co-insurance cost for a three-month supply at an Advantage90™ retail pharmacy may be slightly less than three times the one-month supply co-insurance.

THREE-MONTH SUPPLY THROUGH THE MAIL SERVICE PHARMACY Prescriptions for maintenance medications or long-term health conditions can be ordered through the Walgreens Mail Service pharmacy. Besides being convenient, you could save money! Maximum copayments and co-insurance percentages for the Co-insurance plan are reduced when mail service is used. Level 1 (generic) has 15% co-insurance with a maximum of $28, and Level 2 (preferred brand) has 25% co-insurance with a maximum of $70. For the Consumer Choice Plan, you may save money as many of the medications, especially generics, have a higher discount than medications filled at a retail or Advantage90™ pharmacy. You must use a specific order form when placing your first order so as to provide Walgreens Mail Service with important health, allergy and plan information. This form is called the Tempe Registration and Order Form and is available online at the Employee Benefits Home Page or at *www.mywhi.com*.

If purchasing medication in a three-month supply is financially problematic, consider enrolling in either the Choice Fund HSA medical plan that uses the CIGNA pharmacy plan and does not require you to purchase maintenance medication in three-month quantities, or enrolling in the Health Care Flex Spending Account which provides a debit card. The debit card allows you to pay for your medication in advance of collecting your full annual FSA contribution.

Note: Diabetic supplies and medications may be obtained at a CIGNA Medical Group pharmacy for $10 per item for a 30-day supply. Show your CIGNA ID card since these costs will be charged to your medical plan instead of to your pharmacy plan.

You and/or your covered dependents may voluntarily enroll in the Maricopa County Diabetic Management Program to qualify for free diabetic medications and supplies if you have elected either the Co-insurance or Consumer Choice plan. Once you or your dependents meet the 9 required measures, you will receive all covered diabetic medications and supplies free of charge. You and/or your covered dependents may also voluntarily enroll in the Healthful Living Diabetes Care Management Program. Upon completion of this year-long educational program, you will be reimbursed for up to 9 diabetic-related office visit copays for one plan year. For information regarding these programs or to request enrollment, please call the Employee Benefits Division.

PHARMACY PLAN FOR CHOICE FUND HSA PLAN

ADMINISTERED BY CIGNA

RX BIN# 600428/RX PCN# 02150000

If you enrolled in the Choice Fund HSA medical plan, your pharmacy benefit is provided through CIGNA. The CIGNA plan consists of three-levels where co-insurance is charged after the plan deductible is met, except for preventive medications. The cost of medication may vary per pharmacy. Refer to www.mycigna.com for a cost comparison tool located under “My Plans” tab and then the “Pharmacy” tab. Click on the link “Get a prescription drug price quote” under the “Price a Medication” heading. By clicking this link, you will be able to obtain the cost of your prescription drugs, check for generic drug equivalents, and find out if a specific drug is covered. There is not a separate premium charge for the this plan because it is included in the medical premium.

CIGNA Pharmacy Plan for Choice Fund HSA Plan

Level 1	Generic	30% after deductible
Level 2	Preferred Brand	40% after deductible
Level 3	Non-Preferred Brand	50% after deductible
Certain generic and preferred brand preventive medications are provided at no cost (Deductible does not apply to these preventive medications).		

CIGNA

The information and benefits described herein are brief summaries of the County’s official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

VISION PLAN

Administered by EyeMed Vision Care

If you enroll in any County medical plan, you must enroll (cannot waive) in the vision benefit. The County also offers this plan as a separate (stand-alone) vision plan for employees who choose to waive their medical benefits and wish to enroll in the vision plan.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	$30
Exam Options:		
Standard Contact Lens Fit and Follow-Up*	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up**	10% off retail price	N/A
Frames:		
Any available frame at provider location	$130 allowance, 20% off balance over $130	$50
Standard Plastic Lenses:		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lenticular	$10 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$0	Up to $25
Standard Polycarbonate for Children under 19	$0	Up to $25
Standard Anti-Reflective Coating	$45	N/A
Standard Progressive (Add-on to Bifocal)	$75	Up to $40
Premium Progressive	$75, 80% of charge less $120 Allowance	Up to $40
Other Add-ons and Services	20% off retail price	N/A
Contact Lenses: (Contact lens allowance covers materials only)		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$130
Disposables	$0 Copay, $130 allowance; balance over $130	$130
Medically Necessary	$0 Copay, Paid-in-Full	$250
LASIK and PRK Vision Correction	$150 allowance; once per lifetime per eye	N/A
Frequency:		
Examination	Once every 12 months	
Frame	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)

**Premium Contact Lens Fitting - all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)

Acute Care Benefit: To enable continuity of eye health care services, an Acute Primary eye care program is available to you. The purpose of this program is to provide coverage for acute eye care conditions identified as part of the vision exam as well as those progressive conditions that could result in vision loss. You are covered for urgent eye care conditions, such as 'pink eye', as well as those progressive conditions that result in vision loss. Treatment for chronic conditions such as glaucoma or diabetes (except refraction) must be received through your medical benefit and medical provider.

Additional Discounts

Additional Eyewear - Save up to 40% off additional complete pairs of glasses after the initial benefit has been used. Available at any participating provider

Eye Care Supplies - Receive 20% off retail price for eye care supplies like cleaning cloths and solutions purchased at participating providers (not valid on doctor's services or contact lenses).

Laser Vision Correction - Save 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures.

Replacement Contact Lens Purchases - Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price.

Per Pay Period (24/yr.) Vision Premiums w/Medical Plan	Full-time	Part-time
Employee	$0.00	$0.00
Employee + Spouse	$0.00	$0.00
Employee + Child	$0.00	$0.00
Employee - Family	$0.00	$0.00

Per Pay Period (24/yr.) Vision Premiums w/o Medical Plan	Full & Part-time
Employee	$5.08
Employee + Spouse	$9.58
Employee + Child	$10.04
Employee - Family	$14.74

For more detail, review the vision plan documents on the Employee Benefits Home Page, or contact EyeMed (refer to "Who to Contact" section).

BEHAVIORAL HEALTH PLAN & EMPLOYEE ASSISTANCE PROGRAM

Administered by Magellan Health Services

Maricopa County offers both an Employee Assistance Program (EAP) and Behavioral Health benefit administered by the same company, Magellan Health Services (Magellan). Sometimes employees face problems that they cannot solve. Concerns can become overwhelming and affect work performance, personal happiness, family relations and health. When this occurs, professional help may be needed to resolve the problem before it becomes a larger issue. You will be assisted by a behavioral health professional who will ensure that your treatment is provided at the most appropriate level for your situation (EAP or Behavioral Health benefit).

All employees (including contract and temporary) and the members of their household, including domestic partners, elderly parents, stepchildren, and others such as children in college who may be out of state, qualify for the EAP Program. While there is no specified age limit for services, very small children are often seen as part of a family system. Please contact Magellan if you have specific questions on who qualifies for EAP. The Behavioral Health benefit if limited to employees who have enrolled in a CIGNA medical plan (except for CIGNA Choice Fund Health Savings Account that has behavioral health coverage through CIGNA Behavioral Health) and their dependents that are covered under that plan. For details about the EAP and behavioral health benefit, refer to the Magellan brochure and Behavioral Health Summary Plan Document located on the EBC/Intranet at *http://ebc.maricopa.gov/ehi* or on the Internet Web site at *www.maricopa.gov/benefits*.

EAP

The Employee Assistance Program (EAP) offered through Magellan is an employer-paid benefit for active employees (not for COBRA participants or retirees) that provides short-term counseling for both personal and work-related issues for you and your dependents. There is no premium charged to you for this benefit and there is no copayment when you use this service.

Your EAP provides a full range of counseling and referral services for individual, family and marital concerns, stress and job-related matters, child and domestic abuse, and legal or financial issues. Counseling is available by phone or in person, depending on your preference.

Counseling

Your EAP benefit provides up to eight individual counseling sessions for you and your dependents per person, per problem, per year. If sufficient need is shown, upon your approval, your counselor may encourage other member of your family to participate. Magellan provides the strictest confidentiality possible, as set forth in state and federal statutes. Release of information by the EAP concerning an individual can be given only with your written consent, except where required by law (e.g., when child abuse is suspected or when posing a danger to self or others).

Legal Consultation

Your EAP provides legal consultation services. You can call to be referred to an attorney for a prepaid initial in-person consultation or for an immediate telephonic consultation on issues such as estate planning, family and divorce law, civil and criminal matters, and more.

Financial Counseling

Your EAP also includes services to help you reach your financial goals. When you call, you'll be put in touch with a financial expert who can provide information and answer questions on a wide range of topics, including planning for retirement, debt consolidation, and more.

For more information regarding the EAP benefit or to make an appointment, contact Magellan at 888-213-5125, 24 hours a day, seven days a week or online at *www.magellanassist.com*.

Behavioral Health and Substance Abuse

The behavioral health benefit provides services that support your well-being. These services help you deal with a wide range of issues, including:

Substance abuse	Anger management	Depression
Severe stress and anxiety	Eating disorders	Grief and loss

Through these services, you receive confidential counseling whenever you and/or your eligible dependents are faced with a personal challenge. Protecting your confidentiality is Magellan's top priority. All records, including personal information, referrals and evaluations, are kept confidential in accordance with federal and state laws.

The adjacent table is a summary of your benefits. **All in-network services require prior approval by Magellan before services are received.** Higher levels of care for out-of-network providers (such as inpatient, residential, intensive outpatient, and partial hospitalization) also require prior approval. However, out-of-network outpatient individual or group counseling services do not require prior approval.

For more information regarding the Magellan behavioral health and substance abuse benefit, claims payment, to obtain prior approval or to find a participating provider, contact Magellan, 24 hours a day, seven days a week. Refer to "Who to Contact" section. Claims should be mailed to: Magellan, P.O. Box 1098, Maryland Heights, MO 63043.

Magellan Behavioral Health and Substance Abuse Benefits

Level of Care	In-Network Benefit	In-Network Rules	Out-of-Network Benefit	Out-of-Network Rules
Inpatient Hospitalization	30 days per year are shared between in and out-of-network benefits $25 copay per day	Preauthorization required	30 days per year are shared between in and out-of-network benefits $500 deductible Plan pays $250 per day after deductible is met. All other costs after plan payment of $250 are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain pre-authorization results in no reimbursement
Partial Hospitalization	Benefit is derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year 30 partial day per year are shared between in and out-of-network benefits Trade at 2 partial days for 1 inpatient day $20 copay per day	Preauthorization required	Benefit derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year 30 partial days per year are shared between in and out-of-network benefits Trade at 2 partial days for 1 inpatient day $250 deductible Plan pays $125 per day after deductible. All costs after plan payment of $125 are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain preauthorization results in no reimbursement
Residential	60 days per year $12.50 copay per day	Preauthorization required	No benefit	N/A
Intensive Outpatient (IOP)	45 IOP visits per year are shared between in and out-of-network benefits $100 copay per program	Preauthorization required $100/program copay applies to a continuous episode of care in IOP. If patient discontinues & restarts program, a new $100 copay is applied	45 IOP visits per year are shared between in and out-of-network benefits Plan pays $40 per visit. All other costs after plan payment of $40 per visit are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain preauthorization results in no reimbursement
Outpatient therapy (individual, family, and medication evaluation)	30 visits per year are shared between in and out-of-network benefits $20 copay per visit	Preauthorization required	30 visits per year are shared between in and out-of-network benefits Plan pays $25 per visit. All other costs after plan payment of $25 per visit are member's responsibility	No preauthorization
Outpatient Group Psychotherapy	60 visits per year are shared between in and out-of-network benefits $5 copay per visit	Preauthorization required	60 visits per year are shared between in and out-of-network benefits Plan pays $15 per visit. All other costs after plan payment of $15 per visit are member's responsibility	No preauthorization
Ongoing Medication Management	$10 copay per visit Not subject to Outpatient visit limits	Preauthorization required	Plan pays $25 per visit. All other costs after plan payment of $25 per visit are member's responsibility Not subject to Outpatient visit limits	No preauthorization
Lifetime Maximums	No lifetime maximum		$5 million lifetime maximum	
Annual Limits:	Autism coverage, in accordance with ARS, is limited to $50,000 per plan year up to age 9 and $25,000 per plan year between the ages of 9-16.			

The premium for the behavioral health benefit health benefit is included in the medical premium.

CIGNA Behavioral Health and Substance Abuse Benefits for Choice Fund HSA Plan

Mental Health and Substance Abuse	In-network	Out-of-network
Inpatient	90% after plan deductible; 60 days combined maximum per plan year	70% after plan deductible; 60 days combined maximum per plan year
Outpatient	90% after plan deductible; 20 visits combined maximum per plan year	70% after plan deductible; 60 days combined maximum per plan year
Outpatient Group Therapy Mental Health (MH) *(One group therapy session equals one individual therapy session)*	90% after plan deductible	Subject to the same co-insurance and medical plan deductible as Outpatient MH visits
Intensive Outpatient Mental Health *Maximum: Up to 3 programs per plan year based on ratio of 1:1 with outpatient MH visits*	50% after plan deductible	50% after plan deductible
Annual Limits:	Autism coverage, in accordance with ARS 20-826.04, is limited to $50,000 per plan year up to age 9 and $25,000 per plan year between the ages of 9-16.	

The premium for the behavioral health benefit health benefit is included in the medical premium.

COMBINED RATE SHEET

Per Pay Period Total Medical Rates 24 times/plan year
(Includes Medical, pharmacy, behavioral health, vision)

Reduce $20/applicable pay period for tobacco free household (employee and covered dependents)
Reduce $5/applicable pay period if the employee voluntarily participates in the biometric screening initiative
Reduce $5/applicable pay period if the employee voluntarily participates in the health assessment initiative

CMG High option + Co-insurance Rx	Full-time	Part-time
Employee	$42.03	$139.85
Employee + Spouse	$65.62	$157.05
Employee + Child(ren)	$51.70	$151.00
Employee + Family	$89.13	$167.27

CMG High

CMG High option + Consumer Choice Rx	Full-time	Part-time
Employee	$36.68	$134.66
Employee + Spouse	$55.03	$146.75
Employee + Child(ren)	$43.74	$143.27
Employee + Family	$73.24	$151.81

CMG Low option + Co-insurance Rx	Full-time	Part-time
Employee	$39.69	$104.04
Employee + Spouse	$57.71	$121.11
Employee + Child(ren)	$47.32	$115.85
Employee + Family	$75.05	$128.59

CMG Low

CMG Low option + Consumer Choice Rx	Full-time	Part-time
Employee	$34.34	$98.85
Employee + Spouse	$47.12	$110.80
Employee + Child(ren)	$39.36	$108.12
Employee + Family	$59.16	$113.13

OAP In-Network + Co-insurance Rx	Full-time	Part-time
Employee	$51.14	$157.73
Employee + Spouse	$113.52	$176.79
Employee + Child(ren)	$89.99	$170.50
Employee + Family	$154.05	$187.93

OAPIN

OAP In-Network + Consumer Choice Rx	Full-time	Part-time
Employee	$45.79	$152.54
Employee + Spouse	$102.93	$166.49
Employee + Child(ren)	$82.03	$162.77
Employee + Family	$138.16	$172.47

OAP High option + Co-insurance Rx	Full-time	Part-time
Employee	$52.08	$163.12
Employee + Spouse	$114.46	$183.52
Employee + Child(ren)	$90.86	$176.73
Employee + Family	$155.55	$195.91

OAP High

OAP High option + Consumer Choice Rx	Full-time	Part-time
Employee	$46.73	$157.93
Employee + Spouse	$103.87	$173.22
Employee + Child(ren)	$82.90	$169.00
Employee + Family	$139.65	$180.45

OAP Low option + Co-insurance Rx	Full-time	Part-time
Employee	$39.97	$109.49
Employee + Spouse	$58.35	$122.52
Employee + Child(ren)	$47.64	$117.85
Employee + Family	$76.35	$130.46

OAP Low

OAP Low option + Consumer Choice Rx	Full-time	Part-time
Employee	$34.62	$104.30
Employee + Spouse	$47.76	$112.22
Employee + Child(ren)	$39.68	$110.12
Employee + Family	$60.46	$115.00

Choice Fund HSA + CIGNA Rx	Full-time	Part-time
Employee	$30.00	$131.47
Employee + Spouse	$30.00	$147.23
Employee + Child(ren)	$30.00	$141.39
Employee + Family	$30.00	$156.95

Choice Fund HSA

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DENTAL PLAN SUMMARY CHART

Administered by:	Employers Dental Solutions (EDS)		CIGNA Dental*		Delta Dental**	
Type of Plan	DCO (Dental Care Organization)		PPO		PPO (but does not use PPO network; see network below.)	
Service Area Where Care Must be Received	Maricopa County		National		National	
Residency Requirement	No		No		No	
Primary Care Dentist Required	Yes, all family members must choose the same dentist		No		No	
Referral Required	No		No		No	
Out-of-Network Coverage	No		Yes		Yes	
Network	EDS Provider Network		CIGNA Dental Network		Delta Premier Network	
Prior Authorization	No		No, predetermination recommended for services over $250		No, predetermination recommended for services over $250	
Location of Provider Directory	*www.mydentalplan.net*		*www.cigna.com*		*www.deltadentalaz.com*	
Per Pay Period (24/yr.) Dental Premiums	**Full-time**	**Part-time**	**Full-time**	**Part-time**	**Full-time**	**Part-time**
Employee	$2.16	$2.16	$7.23	$12.02	$11.92	$16.74
Employee + Spouse	$4.10	$4.10	$15.95	$27.45	$26.31	$37.81
Employee + Child(ren)	$5.38	$5.38	$17.25	$28.37	$28.44	$39.56
Employee + Family	$6.18	$6.18	$22.18	$37.48	$36.57	$51.87

*Includes the CIGNA Dental Oral Health Integration Program®.

**Includes enhanced dental benefits for pregnant women and persons with diabetes.

For more information about these dental wellness programs, see the "Wellness Initiatives and Incentives" section.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

DENTAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		EDS*	CIGNA Dental***		Delta Dental	
		In-Network coverage only	In and Out-of-Network coverage			
Deductible	Individual	$0	$50		$50	
	Family	$0	$100		$100	
Annual Individual Benefit Maximum	Standard	None	$2,000		$2,000	
	Orthodontic	None	$3,000		$3,000	
Pre-existing Condition Limitation		Procedures in progress at time of enrollment are not covered	5 year waiting period for replacement (major services)		5 year waiting period for replacement (major services)	
Class I - Preventive Care Services			**Amount Paid by the Member**			
Preventive Care Routine Cleanings Sealants Space Maintainers		$0 $12/tooth $20 + lab fees	In-Network	Out-of-Network**	In-Network	Out-of-Network**
			Deductible waived			
			$0	20%	$0	$0
Diagnostic Exams Evaluations Consultations & X-rays		Copay $0-$20	Deductible waived			
			$0	20%	$0	$0
Emergency Palliative Treatment Treatment for the relief of pain		Up to $200 reimbursement less applicable copay	Deductible waived			
			$0	20%	$0	$0
Class II - Basic Restorative Services			**Amount Paid by the Member**			
Restorative Fillings		Amalgam $8-$21 Resin $22-$40	Amalgam 20% Resin 50%	Amalgam 40% Resin 50%	Amalgam 20% Resin 50%	Amalgam 20% Resin 50%
Oral Surgery Extractions		From $35	20%	40%	20%	20%
Endodontics Root Canal Treatment Pulpotomy		Copay $170-$265	20%	40%	20%	20%
Periodontics Treatment of gum disease Periodontal Maintenance		Debridement: $80 Root Planing: $90	20%	40%	20%	20%
Bridge & Denture Repair		$10 + lab fees	20%	40%	20%	20%
Class III - Major Restorative Services			**Amount Paid by the Member**			
Prosthodontics Bridges per pontic Partial Dentures Complete Dentures (upper or lower)		$250 + lab fees $375 + lab fees $325 + lab fees	50%		50%	
Restorative Cast Crowns & Jackets Onlays & Inlays		$250 + lab fees $135 - $170	50%		50%	
Class IV - Orthodontic Services			**Amount Paid by the Member**			
Orthodontic maximum is separate from annual benefit maximum		25% discount children & adults	50% children & adults		50% Adults & children age 8 + older	

*Specialist Care & treatment of TMJ are offered at a discount.

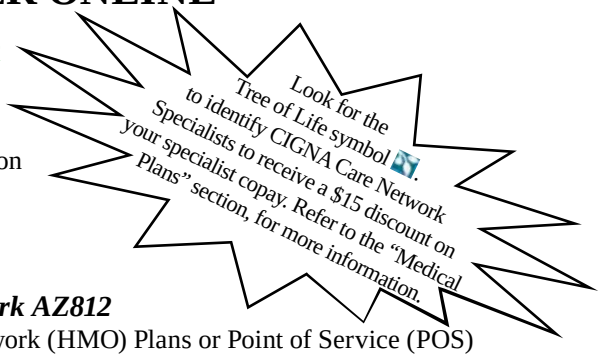
**If the dentist charges more than the reasonable & customary allowance, you will be liable for the difference between the allowance and the billed amount, in addition to the applicable deductible and co-insurance.

***Progressive/Regressive Base Plan effective July 1, 2008. If you enroll in this plan and you or your covered dependents receive a preventive service during the plan year, the level of coverage is increased for that person by 5% for Class II and Class III services for the next plan year. If you don't receive a preventive service during the plan year, the level of coverage is decreased by 5% for these services for the next plan year. However, level of coverage will not go below that listed above.

For more detail, review the dental plan documents on the *Employee Benefits Dental Page*, or contact the vendor (refer to "Who to Contact" section)

HOW TO LOOK UP A PROVIDER ONLINE

CIGNA Medical and Dental Plans – Start at www.cigna.com



1. From the home page, select the Provider Directory link (at top of screen)
2. For medical, enter your physician search information
   For dental, select the radio button next to Dentist and enter the search information
3. Click on the "Next" button
4. Continue with the applicable instructions below

CMG High and Low Options use the AZ – CIGNA Medical Group Network AZ812

1. On the next page, under "What type of plan you have" section, choose "Network (HMO) Plans or Point of Service (POS) Plans"
2. From the "Network (HMO) Plans or Point of Service (POS) Plans" drop-down list, select AZ-CIGNA Medical Group
3. Under "What you're looking for" section, select "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list
4. Click on the "Search" button to view the provider search response

OAP In-Network and OAP High and Low Options use the National Open Access Plus Network AZ300

1. On the next page, under the "What type of plan you have" section, choose "Open Access Plus Only"
2. Under "What you're looking for" section, select "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list
3. Click on the "Search" button to view the provider search response

Choice Fund Health Savings Account (HSA) use the National Preferred Provider Network AZ011

1. On the next page, under "What type of plan you have" section, choose "Preferred Provider Organizations (PPO)"
2. Under "What you're looking for" section, select a physician listed under the "Specialist" area and the type from the corresponding drop-down list
3. Click on the "Search" button to view the provider search response

CIGNA Dental

On the next page, under "What type of plan you have" section, choose "CIGNA Dental PPO or CIGNA Dental EPO" and select "Core Network" from the drop-down list. Click on the "Search" button to view the dental search response.

Other Dental Plans

EDS

1. Start at *www.mydentalplan.net*
2. From the Home page, under the Members Tool section, click on the "Dentist Search" link
3. You can search by city, dentist's last name or download a provider directory

Delta Dental

1. Start at *www.deltadentalaz.com*
2. Click on Dentist and then Dentist Search
3. When a new page appears, under "1. Product Selection", select "Dental Premier" and continue entering the identifying information
4. Or call 602-938-3131 and select 5 and enter the zip code to hear a listing of dentists in your area

Vision Plan

EyeMed Vision Care

1. Start at *www.eyemedvisioncare.com*
2. From the Home page, in the left menu section, click on the drop-down box labeled "Select Your Network" and choose the "Select" option.
3. Enter your zip code where indicated and click the "Submit" button
4. A new window will open and ask you to enter text in the box, click the "Submit" button after entering the text

LIFE INSURANCE PLAN
Fully Insured by The Standard

Your basic and additional life insurance, basic and voluntary accidental death and dismemberment insurance, and dependents life insurance benefits are provided through the Standard Insurance Company ("The Standard"). Evidence of insurability may be required when you make your election for additional life insurance depending on the level requested and the total value of your basic and additional life insurance. Evidence of insurability will also be required for late application for additional life insurance, or for dependents life insurance benefits when electing amounts above the guarantee issue amount or if electing for any amount at any time after you did not make an election when initially eligible. Once you purchase additional life or dependents life insurance, you can reduce it or cancel it at any time.

Basic Term Life with Basic Accidental Death & Dismemberment Insurance

The County provides you with, and pays 100% for, a basic term life insurance and basic accidental death and dismemberment (AD&D) insurance equal to your base annual salary (excluding overtime, bonus, commissions, or special work assignment pay and including management and professional assignment pay) rounded up to the next highest $1,000 to a maximum of $500,000. Coverage becomes effective on the date an elected official becomes eligible, and on the first day of the calendar month following the date any other employee becomes eligible. Life benefits are paid for any cause of death. In addition to the death benefit, basic AD&D benefits up to the amount of basic life coverage may be payable if an accident is the cause of death or if a dismemberment occurs. Evidence of insurability is not required for basic life and basic AD&D coverage (except if you were eligible under the prior life insurance plan with Unum Life Insurance Company for more than 31 days but were not insured).

Additional Life Insurance

If you want to add to your basic level of coverage, you can apply for additional life insurance. You pay all of the premium for additional life insurance. Evidence of insurability is required for additional life when the coverage requested is greater than the guarantee issue amount of $500,000.

The amount of your life insurance coverage may not exceed $1 million of basic life and additional life combined. The amount of your AD&D insurance coverage may not exceed $1 million of basic AD&D and voluntary AD&D combined.

If you purchase additional life insurance at the time you are a new hire or when first eligible, you may elect coverage in amounts of 1, 2, 3, 4 or 5 times your annual salary rounded up to the next $1,000. Evidence of insurability will be required for an amount greater than $500,000. If you elect more than $500,000, you will be enrolled for coverage up to $500,000 until your evidence of insurability application for the amount in excess of $500,000 has been approved.

If you didn't enroll in additional life insurance as a new hire or when first eligible, you may apply for any level of coverage (1, 2, 3, 4 or 5 times your annual salary) at any time but evidence of insurability will be required.

If you experience a qualified status change, you can, within 30 calendar days of that change, add or increase additional life coverage (1, 2, 3, 4 or 5 times your annual salary) without evidence of insurability, unless the requested amount is greater than $500,000. If you elect more than $500,000 and if you are not approved for the increase in coverage, you will remain at your current level (same level you had prior to applying for the increase). However, if your current level is less than $500,000, your coverage will be increased to the next level as long as that level does not exceed $500,000. To learn what constitutes a qualified status change, refer to the "What is a Qualified Status Change?" section.

During an open enrollment period, you can increase your additional life coverage by one level without evidence of insurability, provided the increased amount does not exceed $500,000. If you wish to increase your coverage by more than one level or if the increased amount is over $500,000, you must complete an Evidence of Insurability application. If you do not complete the Evidence of Insurability application or if you are not approved for the increase in your coverage, you will remain at the same level you had prior to applying for the increase. However, if your current level is below the guarantee issue amount of $500,000, your coverage will be increased to the next level.

Evidence of Insurability

Evidence of insurability is required for a member or dependent for additional life insurance or dependents life insurance when:

- electing an amount in excess of the guarantee issue limit; and
- increasing coverage beyond the amount allowed during open enrollment and qualified status change
- benefits are reinstated
- applying more than 30 calendar days after you become eligible (late applicant)
- increasing dependents life insurance or electing dependents life insurance after initially eligible

Evidence of insurability is not required for voluntary AD&D insurance. The Evidence of Insurability (Medical History Statement) application is available at *www.standard.com/mybenefits/maricopa*.

For all employees who are required to complete an Evidence of Insurability (Medical History Statement) application, The Standard will review the information and make a determination whether to approve or deny your request for additional coverage. The Standard may request further information, including, but not limited to, medical records, when making a determination. Coverage and the associated premium do not become effective until The Standard approves your request. For new hires, the effective date of coverage is the first day of the pay period next following the date your application is approved. Other approved increases are effective the first day of the calendar month next following the date your application is approved, or the following July 1 if you apply during an open enrollment period.

Life Features

- Repatriation
  - Available when death occurs more than 75 miles from the insured's primary residence
  - Reimburses the lesser of 2% of life benefit (Basic and Additional) or $2,500, for transportation of an insured's remains to a mortuary near the primary residence
- Accelerated Benefit
  - Applies to insured who is terminally ill with 12 or less months to live
  - Limited to 50% of Basic and Additional life
- Assignment
  - Benefits are not assignable

Medex® Travel Assist Benefit - Group# 7088

Medex® is a comprehensive program of information, referral, assistance, transportation and evacuation services when eligible members are traveling more than 100 miles from home or in a foreign country. The Medex brochure, which contains the ID card, is posted on the Employee Benefits Web site and on the Standard's Web site.

- Services
  - Pre-Trip assistance
  - Medical assistance
  - Emergency transportation services
  - Travel assistance
  - Personal security
  - Medical supplies
- Eligibility
  - Any Maricopa County employee covered by The Standard's Group Life insurance plan and his/her eligible dependents (spouse and/or unmarried dependent children under age 19 or through age 24 if a full-time student)

Special Rate for Non-Tobacco Users

As part of the County's commitment to good health, a reward is offered for leading a healthier lifestyle. If you are not a tobacco user, your life insurance premiums are lower than those of an employee who uses tobacco. Note: Misstatement of tobacco use status may result in the life insurance company rescinding coverage at time of death.

5 Year Age Categories *(Age on last January 1)*	**Employee Cost Monthly per $1,000 of Coverage** *(Non-Tobacco User Multiplier)*	**Employee Cost Monthly per $1,000 of Coverage** *(Tobacco User Multiplier)*	*Smoker rates are controlled by your response to tobacco-use questions on the Additional Life Plan page in the Benefit Enrollment System. Misstatement of your tobacco use status may result in the life insurance company rescinding coverage.*
Under 25	$0.040	$0.065	
25-29	$0.047	$0.070	
30-34	$0.062	$0.080	
35-39	$0.070	$0.136	
40-44	$0.092	$0.194	
45-49	$0.150	$0.385	
50-54	$0.230	$0.709	
55-59	$0.390	$0.722	
60-64	$0.660	$1.120	
65-69	$0.950	$1.370	
70 and older	$1.760	$2.250	

Additional Life Insurance Premium Calculator Example

If you are enrolling online through the Benefit Enrollment System, the system calculates your premium automatically.

Take your annual base salary - **example: $24,500**					
Round up to the nearest $1,000	$25,000	$25,000	$25,000	$25,000	$25,000
Multiply by coverage level	1x Salary	2x Salary	3x Salary	4x Salary	5x Salary
Salary amount	$25,000	$50,000	$75,000	$100,000	$125,000
÷ divided by $1,000	**25**	**50**	**75**	**100**	**125**

Refer to the Additional Life Insurance table above to find your age category and tobacco-user or non-tobacco user multiplier

Multiply the result (25, 50, 75, 100, or 125) from the last calculation in the table above by the applicable age and tobacco/non-tobacco user multiplier; then divide by 2 to calculate the per pay period premium (24/yr.)

Example: Age 37	**Multiplier for Non-Tobacco User $0.070**	**Multiplier for Tobacco User $0.136**	**Coverage Amount**
1 x Salary	$0.070 x 25 = $1.75/2 = **$0.88**	$0.136 x 25 = $3.40/2 = **$1.70**	$25,000
2 x Salary	$0.070 x 50 = $3.50/2 = **$1.75**	$0.136 x 50 = $6.80/2 = **$3.40**	$50,000
3 x Salary	$0.070 x 75 = $5.25/2 = **$2.63**	$0.136 x 75 = $10.20/2 = **$5.10**	$75,000
4 x Salary	$0.070 x 100 = $7.00/2 = **$3.50**	$0.136 x 100 = $13.60/2 = **$6.80**	$100,000
5 x Salary	$0.070 x 125 = $8.75/2 = **$4.38**	$0.136 x 125 = $17.00/2 = **$8.50**	$125,000

Voluntary AD&D Benefits

This plan also offers voluntary AD&D insurance from The Standard. With voluntary AD&D insurance, you or your beneficiaries may be eligible to receive an additional amount in the event of death or dismemberment as a result of an accident.

Eligible employees may choose voluntary AD&D coverage of 1, 2, 3, 4 or 5 times their base annual salary, rounded to the next $1,000. The maximum amount is $500,000.

You may elect voluntary AD&D coverage for yourself only for individual coverage, or you may elect family coverage for you and your spouse and child(ren). If you elect family coverage, the amount of AD&D coverage for your spouse and child(ren) will be a percentage of your voluntary AD&D insurance as follows:

- Spouse only: 60%
- Child(ren) only: 10% for each child, not to exceed $25,000
- Spouse and child(ren): 50% for your spouse; 5% for each child

You are not required to elect additional life coverage in order to elect voluntary AD&D.

Voluntary Accidental Death & Dismemberment Family Monthly Cost
$0.035 per $1,000
Employee Only Cost
$0.02 per $1,000

Other voluntary AD&D benefit features are listed below:

- Seat Belt
  - Lesser of $25,000 or 10% of AD&D benefit payable for loss of life
    - Applies to an insured driver or passenger as evidenced by police report
- Airbag
  - Lesser of $15,000 or 5% of the AD&D benefit payable for loss of life
    - Applies if seat belt benefit is payable for an insured driver or passenger in position to be protected by airbag as evidenced by police report
- Career Adjustment
  - Lesser of $10,000 or 25% of AD&D benefit; $5,000 per year maximum
    - Payable to surviving spouse
    - Pays tuition expense up to three years after death
- Child Care
  - Maximum of 3% of the amount of the AD&D benefit up to a $2,000 per year maximum
    - Payable to surviving spouse for eligible child(ren)
    - Pays child care expenses (for a licensed provider) up to 72 months after death

- Higher Education
  - Lesser of $40,000 or 25% of AD&D benefit; $10,000 per year maximum
    - Available to surviving child(ren) at or near high school/college age
    - Pays tuition expense up to four years after member's death
- Line of Duty
  - Lesser of $50,000 or 100% of the amount of AD&D benefit payable for the loss of insured public safety officer (does not include corrections, probation, parole or judicial officers)
- Occupational Assault
  - Lesser of $25,000 or 100% of the amount of AD&D benefit payable for the loss if assaulted while actively at work as evidenced by police report
- Public Transportation
  - Lesser of $200,000 or 100% AD&D benefit payable for loss by a fare paying passenger on public transportation

AD&D Exclusions

AD&D benefits are not payable for death or dismemberment caused by or contributed by:

- War or acts of war
- Suicide or other intentionally self-inflicted injury
- Injuries sustained while committing or attempting to commit a felony
- Any drug not used in accordance to the directions of a physician
- Sickness, pregnancy, heart attack or stroke
- Medical or surgical treatment for any of the above
- Boarding, leaving, or being in or on any kind of aircraft. However, this exclusion will not apply if the person who suffers the loss is a fare paying passenger on a commercial aircraft.
- Any loss caused by an accident which arises out of or in the course of any employment for wage or profit.

Dependents Child and Spouse Life Coverage

In addition to basic and additional life insurance for yourself, you may elect dependents life insurance for your eligible dependents (legal spouse and children).

Note: You may not cover your spouse as a dependent if he or she is enrolled for basic life coverage as a Maricopa County employee. Additionally, if you and your spouse are both County employees, only one may enroll dependent children for coverage. These enrollment rules are not monitored by the County because our system does not have an indicator advising if two County employees are married to each other. It is therefore your responsibility to properly enroll in dependents life insurance. Premiums paid for coverage of ineligible dependents will not be reimbursed if you fail to comply with these enrollment requirements.

Child Life

Child Life coverage may be purchased for the employee's dependent child(ren) from live birth to age 19, or to age 25 if a full-time student. Coverage may also be purchased for a continuously disabled child(ren). You must provide proof of disability to The Standard within 30 days after a) the date insurance would otherwise end because of the child's age or b) the effective date of Maricopa County's coverage under The Standard's policy, if you child is disabled on that date. Contact The Standard to obtain the appropriate form to complete for a disabled child.

Coverage is available initially in increments of $5,000, from $5,000 to a maximum of $20,000. The child coverage amount may not exceed the total amount of the employee's life insurance (basic and additional life combined). Evidence of insurability is required for child coverage amounts greater than $10,000. Once insured, all enrollments and increases require evidence of insurability.

Children (live birth to 25 years if full-time student)	
Monthly Cost	Coverage Amount
$0.50	$5,000
$1.00	$10,000
$1.50	$15,000
$2.00	$20,000

Spouse Life

Spouse Life coverage may be purchased for the employee's legal spouse initially in increments of $10,000, from $10,000 to a maximum of $100,000. The spouse coverage amount may not exceed the total amount of the employee's life insurance (basic and additional life combined). Evidence of insurability is required for spouse coverage amounts greater than $50,000. Once insured, all enrollments and increases require evidence of insurability.

The premium for Spouse Life coverage is based on the age of the spouse as of January 1 of the current year. In order for the premium to calculate accurately you must ensure that your spouse's age is included on the dependent record in the Benefit Enrollment System. When enrolling in the Benefit Enrollment system initially, the spouse life premium calculates on your age, however, when the final calculation occurs and confirmation statement is produced, the correct spouse life premium will display.

Spouse Life - Monthly Cost	
Age on last January 1	**Spouse**
Under 25	$0.06/$1,000
25-29	$0.07/$1,000
30-34	$0.08/$1,000
35-39	$0.10/$1,000
40-44	$0.12/$1,000
45-49	$0.20/$1,000
50-54	$0.34/$1,000
55-59	$0.54/$1,000
60-64	$0.90/$1,000
65-69	$1.28/$1,000
70 and older	$2.08/$1,000

Claims Process

Claims must be filed no later than one year after the 90 days immediately following the date of loss. When filing a death claim, a certified death certificate is required. Please contact the Employee Benefits Division in the event of a loss of life or an accidental dismemberment. The Benefits Analyst will assist with providing the Beneficiary Statement form to the beneficiary and completing the Proof of Death form.

Summary of Coverage

Coverage	Who is Covered?	Minimum	Maximum	Evidence of Insurability	Who pays premium?	Monthly Premium
Basic Life	Employee Only	1 x salary	$500,000	None	Maricopa County	.10/1,000
Basic AD&D	Employee Only	1 x salary	$500,000 (matches Basic Life amount)	None	Maricopa County	.02/1,000
Additional Life[2]	Employee Only	1 x salary	5 x salary to a combined total of $1M (Basic + Additional) at new hire, newly eligible or status change. May only increase 1 level during Open Enrollment.	>$500,000	Employee	Based on tobacco use status & age
Spouse Dependent Life	Legal Spouse of Employee	$10,000	$100,000 but not more than employee's combined Basic + Additional. Once insured, all increases require EOI.	>$50,000 for initial enrollment. Once insured, all increases require EOI, even at Open Enrollment.	Employee	Based on spouse's age
Child(ren) Dependent Life	Child(ren) as defined in the group policy	$5,000	$20,000 per child, but not more than employee's combined Basic + Additional per child. Once insured, all increases will require EOI.	>$10,000 for initial enrollment. Once insured, all increases require EOI, even at Open Enrollment.	Employee	.10/1,000
Employee Only (Individual) Voluntary AD&D[1]	Employee Only	1 x salary	5 x salary to a maximum of $500,000	Does not apply to AD&D	Employee	.02/1,000
Family Voluntary AD&D[3]	Employee, Spouse and Child(ren)	1 x salary	5 x salary to a maximum of $500,000	Does not apply to AD&D	Employee	.035/1,000

[1]Evidence of Insurability (EOI) is always required for a late applicant (other than a status change or Open enrollment election)

[2]Employee does not have to enroll in Additional Life in order to purchase Voluntary AD&D

[3]Family coverage includes employee and/or legal Spouse and/or Child(ren). Employee may not be insured for Employee Only Voluntary AD&D coverage and Family Voluntary AD&D coverage concurrently. Family coverage amounts are a) 60% of employee's voluntary AD&D amount when only a Spouse is covered; b) 10% of employee's voluntary AD&D amount up to $25,000 maximum when only a Child(ren) is covered; and c) 50% of employee's voluntary AD&D amount for a Spouse and 5% for each Child when both Spouse and Child(ren) are covered.

Portability

If your group coverage ends due to employment termination, retirement or reduction in hours, you may be eligible for portable group basic, additional, AD&D and dependent coverages. The portable insurance is available for up to your current coverage amount up to $1,000,000 for life, $300,000 for AD&D, $100,000 for spouse, and $10,000 for child(ren); or you may decrease the amount of your coverage.

To apply, you must complete the Group Life Insurance Portability form and send it to The Standard along with premium payment within 45 calendar days after your group insurance coverage ends. You and the Employee Benefits Department must complete portions of this form. The form is available on The Standard's Web site.

If you die or become divorced, your dependents may be eligible for portable group insurance coverage. The maximum amount of dependents life insurance that may be continued is the lesser of the amount in effect on the day before the insurance would otherwise end or $100,000 for your spouse and $10,000 for your child. Your spouse must continue insurance in order to continue insurance for a child.

If you are not eligible to apply for portable coverage or your portable coverage ends, you or your dependents may qualify for conversion coverage.

Conversion

When your group life insurance terminates due to termination of benefits while on a leave of absence (see bullets below), you can convert your basic and additional life coverage (not AD&D) to an individual whole life policy. Conversion applies at the end of the following periods.

- If you are not working due to injury or sickness, you can continue to be covered through the end of the pay period following 180 days from the date your approved, unpaid leave status began.
- If you are on a military leave of absence, you will be covered through the end of the pay period following 180 days from the date your military leave of absence began.
- If you are on an approved personal leave of absence, you will be covered through the end of the pay period following 90 days from the date your leave of absence began.

To apply for conversion, you must complete the Application for Conversion of Group Insurance and send it along with premium payment to The Standard within 45 calendar days after your group insurance coverage ends. You and the Employee Benefits Division must complete portions of the form before it is mailed. The form is available on the Standard's Web site.

Beneficiaries

You should name a beneficiary for your basic and additional life insurance benefits when you become insured. You may name primary and secondary beneficiaries, and you may name more than one beneficiary as primary and more than one beneficiary as secondary.

You may allocate benefits by percentage only using a whole percentage. Primary beneficiary designations must equal 100%. Secondary beneficiary designations also must equal 100%.

You may change your beneficiary at any time. The new beneficiary designation will be effective as of the date you submit an electronic designation during open enrollment or make a beneficiary change online through the Benefit Enrollment system.

This information is only a brief description of the group Basic Life/AD&D, Additional Life/AD&D insurance policy.
For more complete details of coverage, go to The Standard's Web site or contact The Standard. Refer to the "Who to Contact" section.

SHORT-TERM DISABILITY PLAN

Administered by Sedgwick CMS

The Short-term Disability Plan (STD) replaces a portion of your monthly salary while you are disabled. There is a 3-week waiting period from the onset of your disability during which time you are required to use sick leave. If you do not have enough sick leave, you must use vacation time. If you have more than 3 weeks sick leave, you must use all of it before benefits begin. The maximum payment STD period is 23 weeks (26 week benefit - 3 week waiting period = 23 week payment period). Any sick leave in excess of the 3-week waiting period reduces the 23-week payment period.

What benefit coverage amount can you elect?

You elect the benefit coverage amount when you enroll for STD coverage. You may elect 40%, 50%, 60% or 70% of your monthly salary. The maximum benefit is $1,000 per week.

Note: If your weekly disability payment will be at the $1,000 per week maximum, you may be enrolling in a coverage level with a higher multiplier than necessary. Refer to the STD calculator on the Employee Benefits home page to determine the coverage level

that charges the lowest premium that will yield the $1,000 per week maximum.

You may only increase or decrease your coverage during Open Enrollment. No changes will be allowed during the plan year (July 1 through June 30) except when ineligible for benefits (for example, you lose your active employee status due to a reduction in force or when called to active military duty).

This plan contains a pre-existing condition if you have a condition related to your disability for which you received treatment 90 days before your coverage became effective. In this case, benefits will not be payable for that condition until you have been treatment free for 3 months or covered by the plan for 12 months.

Coverage level changes made during Open Enrollment that result in an increase in coverage are subject to the pre-existing condition. For example, if you previously elected 50% benefit coverage and during an Open Enrollment period changed your election to 70% benefit coverage, the difference between the 50% and the 70% benefit is subject to pre-existing condition payment criteria. If you become disabled due to a pre-existing condition, your payment will be based on the 50% benefit coverage level.

If your claim is related to a mental health diagnosis, Sedgwick CMS will work with Magellan Health Services to ensure that you receive a disability assessment and care by a licensed mental health professional and that you are assigned a care coordinator who will regularly work with you, Sedgwick CMS and your mental health provider on your treatment plan and your return-to-work goals.

The STD benefit includes a return-to-work incentive designed to lessen the financial hardship that your disability caused by allowing you to return to work on a part-time basis within your restrictions and limitations. Your STD benefit continues to be paid, within certain limits, in addition to your part-time earnings. Refer to the STD Summary Plan Document for an example of this calculation.

How is your benefit payment calculated?

To calculate the amount of your weekly benefit, multiply your weekly earnings by the percentage of the benefit coverage amount you elected and deduct any other income you are receiving that offsets your benefit. Premiums for your health benefits will also be deducted.

Benefits payable for less than one weekly period will be pro-rated at the rate of one-seventh of the STD benefit amount for each day of disability.

Coverage	Multiplier
40%	0.38%
50%	0.55%
60%	0.85%
70%	1.32%

Premium Calculation Example

Annual Base Salary: $25,000	40% Option	50% Option	60% Option	70% Option
Multiplier	0.0038	0.0055	0.0085	0.0132
Per Pay Period Multiplier (Multiplier x (26/24))	0.0041	0.006	0.0092	0.0143
Per Pay Period Salary (Annual Salary / 26)	$961.54	$961.54	$961.54	$961.54
Per Pay Period Premium (Per Pay Period Salary x Per Pay Period Multiplier)	$3.94	$5.77	$8.85	$13.75

Refer to the Short-Term Disability Summary Plan Document on the Employee Benefits Web site for further details or contact Sedgwick CMS (refer to the “Who to Contact” section).

The information and benefits described herein are brief summaries of the County’s official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

FLEXIBLE SPENDING ACCOUNTS

Administered by ADP

Maricopa County offers two flexible spending accounts (FSA) that allow you to pay for health care and/or day care expenses on a tax-free basis for your dependents that you claim as dependents on your federal income tax return. When you elect to participate in an FSA, your gross income is reduced because your FSA contributions are not subject to Medicare, OASDI, federal or state income taxes. Once you enroll in an FSA, you must re-enroll during each Open Enrollment to renew your spending account(s).

When you enroll in the FSA, you will be asked to enter the annual amount of your contribution in the Benefits Enrollment system. The system automatically divides the annual amount by the number of pay periods remaining in the plan year to determine your per pay period deduction. Deductions are taken 26 times during the plan year. Money that is contributed to an FSA will be forfeited per Prop. IRS Reg. Section 1.125-5(c)(1), if not used and/or claimed according to the information and dates below. Forfeited funds revert to the Benefits Trust Fund and are used to offset administrative expenses associated with this plan.

For active employees, eligible health and dependent care expenses must be incurred during the plan year (July 1 through June 30). For health care expenses, there is a 2 1/2 month grace period (the following July 1 through September 15) in which expenses can be incurred in order to use any remaining amount from the prior plan year. For terminated employees, health and dependent care expenses must be incurred by your benefit termination date. There is no grace period for health care expenses in this case.

For active employees, claims for reimbursement for the health care FSA must be submitted by the following November 30. For terminated employees, claims must be submitted within 60 days of your benefit termination date.

For active employees, claims for reimbursement for the dependent care FSA must be submitted by the following August 31. For terminated employees, claims must be submitted within 60 days of your benefit termination date.

Claims can be filed by using your debit card during the current plan year. The debit card can also be used to file claims during the grace period for reimbursement of unused funds from the prior plan year if you have re-enrolled in the FSA for the new plan year. The debit card is provided as a payment convenience. There are various regulations that control when the debit card transaction can be accepted with no follow-up documentation. Generally, pharmacy copays and co-insurance and physician office visit copays do not require documentation. Follow-up claim documentation will be required for some charges so be sure to keep your receipts. You will be notified if you need to send in receipts to substantiate your debit card transaction. Paper claims may also be filed if you pay for the service. To file a paper claim, complete the claim form located on the ADP Web site.

Health Care FSA

You can enroll in the health care FSA (unless you enroll in the Choice Fund HSA medical plan or are covered by an HSA) to pay for eligible health care expenses that are not covered by your insurance such as office visit or prescription copays. Certain over-the-counter products purchased to treat an existing or imminent medical condition may qualify as a covered medical expense. These over-the-counter items include allergy medications, smoking cessation products, aspirin, and cold medications. Eligible expenses are defined by the Internal Revenue Service and can be found in IRS Publication 502. You can set aside up to $5,200 as your plan year contribution.

Because the Walgreens Health Initiatives pharmacy plans require you to purchase maintenance medication in 90-day quantities, it can be very beneficial for you to consider opening an FSA since your full plan year contribution is available as soon as your enrollment if effective.

Limited Use FSA

If you enroll in the CIGNA Choice Fund HSA medical plan, you can still enroll in the FSA. However, you and your covered dependents can only participate in the Limited Use plan. You can set aside up to $5,200 as your plan year contribution. This plan allows you to be reimbursed for dental and vision care services (as defined by the IRS) that are not covered by your insurance.

Dependent Day Care FSA

Dependent care FSAs allow you to use pre-tax money to pay for dependent daycare for your dependents under 13 or your spouse or dependent who is physically or mentally incapable of self-care which gives you and your spouse the ability to work. Refer to IRS publication 503 for more information. You can set aside up to $5,000 as your calendar year maximum contribution.

To find out more about the FSAs including what items are eligible for reimbursement, contact ADP with your specific questions. Refer to the “Who to Contact” section.

DEFERRED COMPENSATION

Administered by Nationwide Retirement Solutions

To enhance your future, Maricopa County offers you a deferred compensation plan. Your pension plan through ASRS or PSPRS was not designed to provide your entire retirement income, which is why participating in a deferred compensation program is an essential step to achieving financial independence upon retirement. A deferred compensation program allows you to contribute money, before it is taxed, to an account. When you withdraw the monies from your deferred compensation account, typically during retirement, you will have to pay the applicable taxes. However, tax is paid only on the amount you withdraw in a given year. Meanwhile, the rest of your investment has the opportunity to continue to grow tax deferred.

Once you enroll, contributions are deducted from your paycheck. You can make changes to the amount of your contribution at any time that your personal situation and needs change. The minimum contribution is $10 per pay period. The maximum contribution is 100% of includible compensation, up to $16,500 for calendar year 2009 if you are under age 50. If you are 50 or older, the catch-up provision allows you to contribute an additional $5,500 in 2009. If you are within three years of retirement, you may qualify to contribute more if you have past dollars to "catch up". For this pre-retirement window only, the maximum amount deferrable is the lesser of twice the normal deferral limit ($33,000) or 100% of includible compensation.

You have more than 35 investment choices as well as a Personal Choice Retirement Account through Schwab if you have at least $5,000 on account. As an added bonus, your money is available to you upon separation from County service with no early withdrawal penalty. Funds are also available for withdrawal for a financial hardship as defined by the IRS or through the loan provision where you can borrow up to 50% of the value of your account with a minimum of $1,000.

To request a consultation with a retirement specialist, contact Nationwide Retirement Solutions or visit their Web site. Refer to the "Who to Contact" section.

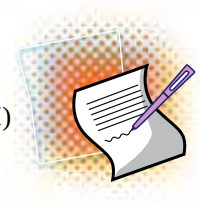
METLAW® GROUP LEGAL SERVICES

Administered by MetLife through Hyatt Legal Plans

Finding an affordably priced lawyer to represent you when you have trouble with creditors, buy or sell your home, or even prepare your will can be a challenge. Now there's a simple, affordable solution. MetLaw is a legal services plan that provides legal representation for you, your spouse and dependents at an affordable price.

Now you have a resource at your fingertips for important, everyday legal services. What's more, you'll also have someone to turn to for unexpected legal matters. With MetLaw, you can receive legal advice and fully covered legal service for a wide range of personal legal matters, including:

- Court Appearances
- Document Review and Preparation
- Debt Collection Defense
- Wills
- Adoption
- Family Matters
- Real Estate Matters
- Traffic Ticket Defense (except DUI/DWI)
- Elder Law Matters
- Security Deposit Assistance



Services are provided from a network of experienced attorneys either on the phone or in person. When you use a Plan Attorney, there are no deductibles, copays, waiting periods, claim forms or limits on usage. You also have the flexibility to use a non-Plan Attorney and get reimbursed for covered services according to a set fee schedule.

The premium for this plan is $7.87 per pay period, 24 pay periods per year.

For more information contact Hyatt Legal Plans or visit their Web site. Refer to the "Who to Contact" section.

AUTO, HOME AND RENTERS INSURANCE

Administered by Liberty Mutual

As a Maricopa County employee, you qualify for a special group discount* on your auto, home and renters insurance through Group Savings Plus® from Liberty Mutual. With Group Savings Plus, you can enjoy the ease and convenience of paying your premiums through payroll or checking account deductions, with no down payment or finance charges. You also will enjoy fast, easy, round-the-clock claims service and a variety of discounts for multi-car, multi-policy, safe-driver, passive restraints and anti-theft devices.*

See for yourself how much money you could save with Liberty Mutual compared to your current insurance carrier. For a free, no-obligation quote, contact Liberty Mutual. Refer to the "Who to Contact" section.

*Discounts and credits are available where state laws and regulations allow and may vary by state. Certain discounts apply to specific coverage only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Coverage is provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA.

ENROLLMENT CHECKLIST

1. Complete your Worksheet that was mailed to your home address to assist in making your enrollment elections quickly in the Benefit Enrollment System.
2. After 15 minutes of inactivity, you will be logged out. Your changes will be saved as long as you go back and finish your elections by 8 PM MST the same day.
3. Register for the portal.
4. Log on to the portal.
5. Click on the Benefits tab.
6. Click on the Benefit Enrollment System link.
7. Read the Welcome page and press Continue.
8. Read the instructions for completing each page, located in the left-hand column.
9. At the Main Menu, click on the appropriate event (Open Enrollment, New Hire, etc.)
10. Review your Personal Information. If incorrect, contact Employee Records at: (602) 506-3519
11. Review your dependents. Dependents must be listed in order to be enrolled in a benefit or for spouse or child life insurance coverage.
12. Review and update your benefit elections.
13. Update your beneficiary information.
14. Review and update your Annual Account elections (for flexible spending accounts and health savings account contributions).
15. Click on the submit button on the Benefit Summary page.
16. Enter your email address if you would like an email acknowledgement or click Cancel.
17. Print your Confirmation page.
18. A Confirmation Statement will be mailed to your home address.
19. Compare the Confirmation page with the Confirmation Statement.
20. If the information on the Confirmation Statement does not match your printed Confirmation page, contact Employee Benefits within 15 calendar days.

ENROLLMENT WORKSHEET EXAMPLE

Maricopa County Employee Health Initiatives
301 S 4th Ave, Suite B100
Phoenix, AZ 85003

2009/2010 Benefits Enrollment Worksheet

ENROLLMENT DEADLINE
05/15/2009

MCYWTST
T4ZV 0001

John Doe
123 N. Central Avenue
Phoenix, AZ 85003

Printed: 05/04/2009
Event: New Hire
Employee ID: 811000000

Enrollment Instructions:

1. Review this Worksheet. You will be enrolled in the benefit coverage marked with a check (✓) unless you make a change.
2. Complete this Worksheet before you go online to make benefit changes.
3. Use the boxes on the left-hand side of the Worksheet to indicate the option code and cost for each benefit you select.
4. Enroll online at http://portal.adp.com by the enrollment deadline shown above.
5. If you do not have access to a computer, check with your department HR Liaison for computer resources that will be available for your use.
6. Paper enrollment or late enrollment will not be accepted. Contact 602-506-1010 if you have enrollment questions.
7. You must register at http://portal.adp.com. Your registration pass code is MCAZ-PRISM09
8. For information regarding the benefits offered, please visit www.maricopa.gov/benefits or the internal Intranet at http://ebc.maricopa.gov/ehi.
9. Review the *Know Your Benefits* booklet for the current plan year or the *What's New* booklet during the annual open enrollment period.
10. This worksheet represents all of your available options. Based on your event you may not be able to make changes to all options.

Dependent Information

You are responsible for adding only eligible dependents and updating any incorrect or incomplete dependent information. The following list displays all individuals who are currently enrolled in benefits as your dependent.

No.	Name	Relationship*	Birth Date	Sex	Student	Disabled	Medical	Dental	Vision
0	JOHN DOE	EE		M			✓	✓	✓

*Relationship codes are:
EE = Employee, SP = Spouse, CH = Child, SC = Step-Child, LG = Legal Guardian, CO = Court-order, BN = Beneficiary

Medical

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
001	CIGNA Medical Group High *	$36.68	$55.03	$43.74	$73.24
002	CIGNA Medical Group Low *	$34.34	$47.12	$39.36	$59.16
003	Open Access Plus In-Network	$45.79	$102.93	$82.03	$138.16
004	Open Access Plus High	$46.73	$103.87	$82.90	$139.65
005	Open Access Plus Low	$34.62	$47.76	$39.68	$60.46
✓006	**Choice Fund - HSA**	$30.00	$30.00	$30.00	$30.00
000	Waived Medical Benefit Plan				

* You are required to provide the code for the Primary Care Provider at the time you enroll. Contact the plan to obtain the PCP code.

Biometric Screening Incentive

Coverage Category/Cost Per Pay Period

Employees (not including dependents) enrolled in a County-sponsored medical plan who participate in the annual Biometric Screening will save up to $120 per plan year on their medical insurance premium. The biometric screening provided by CIGNA Onsite Health consists of completing a brief personal health history as well as having your measurements taken for height, weight, blood pressure, waist circumference, body fat composition, cholesterol, and glucose levels.

2009/2010 Benefits Enrollment Worksheet

Health Assessment Incentive

Coverage Category/Cost Per Pay Period

Employees (not including dependents) enrolled in a County-sponsored medical plan who participate in the annual Health Assessment will save up to $120 per plan year on their medical insurance premium. The Health Assessment is available online through www.mycigna.com and consists of a series of questions about your health and lifestyle. Your confidential responses are then assessed by the online tool to determine your health risks.

Non-Tobacco User Incentive

Coverage Category/Cost Per Pay Period

When employees and all of their dependents enrolled in a County-sponsored medical plan do not use tobacco products (occasionally or regularly), they will save up $480 0 per plan year on their medical insurance premium. Tobacco use includes cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco during the last six consecutive months.

Health Savings Account

When you enroll in the Choice Fund Health Savings Account medical plan, you may contribute to your Health Savings Account on an annual basis. You can contribute up to $3,000 (individual) or $5,950 (family) to your account depending on the amount contributed by Maricopa County. Unused balances in your account rollover each plan year.

Pharmacy

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
001	Co-insurance Prescription Benefit Plan	$5.35	$10.59	$7.96	$15.89
002	Consumer Choice Prescription Benefit Plan	$0.00	$0.00	$0.00	$0.00
✓003	**Choice Fund HSA Prescription Plan**	$0.00	$0.00	$0.00	$0.00
000	Waived Prescription				

Vision

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

If you enroll in any County-sponsored medical plan, you must enroll in the vision plan (EyeMed with Med election). The County also offers this plan as a separate (stand-alone) vision plan for employees who choose to waive their medical benefits and wish to enroll in the vision plan (EyeMed no Med election). However, you may not enroll your dependents in a vision plan if they are not enrolled in your medical plan.

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
✓001	**EyeMed (with Med election)**	$0.00	$0.00	$0.00	$0.00
002	EyeMed (no Med election)	$5.08	$9.58	$10.04	$14.74
000	Waived Vision				

Behavioral Health Coverage

The behavioral health coverage is provided as part of your enrollment in a County-sponsored medical plan and is provided to you at minimal cost. Enrollment is mandatory.

2009/2010 Benefits Enrollment Worksheet

Dental

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
001	Employers Dental Services *	$2.16	$4.10	$5.38	$6.18
002	CIGNA Dental	$7.23	$15.95	$17.25	$22.18
003	Delta Dental	$11.92	$26.31	$28.44	$36.57
✓000	**Waived Dental**				

* You are required to provide the code for the Primary Care Provider at the time you enroll. Contact the plan to obtain the PCP code.

Additional Life Insurance

Your Choice
Option Code
Cost

Basic Life Insurance of 1X Annual Base Salary is provided to you at no cost. You may elect additional coverage from the following options:

Option Code	Coverage Level	Non Tobacco User	Tobacco User
001	1X Annual Base Salary	*Your rates which are based on your base salary and your smoker status will display on your individualized worksheet.*	
002	2X Annual Base Salary		
003	3X Annual Base Salary		
004	4X Annual Base Salary		
005	5X Annual Base Salary		
✓000	**Waived Additional Life**		

Additional Accidental Death and Dismemberment

Your Choice
Option Code
Cost

Basic Accidental Death and Dismemberment (AD&D) Insurance of 1X Annual Base Salary is provided to you at no cost. You may elect additional coverage from the following options:

Option Code	Coverage Level	Employee Only	Employee Plus Family
001	1X Annual Base Salary	*Your rates which are based on your base salary will display on your individualized worksheet.*	
002	2X Annual Base Salary		
003	3X Annual Base Salary		
004	4X Annual Base Salary		
005	5X Annual Base Salary		
✓000	**Waived Additional AD&D**		

Spouse Life Insurance

Your Choice
Option Code
Cost

If there is not a spouse listed on file, the rates on this worksheet will be based on the employee's age. Once your spouse is on file the rates will be adjusted based on the spouse's age. The rates on the confirmation statement will be the adjusted rate.

Option Code	Coverage Level	Cost Per Pay Period	Option Code	Coverage Level	Cost Per Pay Period
001	$10,000	*Rates which are based on your spouse's age at the beginning of the calendar year will display on your individualized worksheet if the spouse's information is on file.*	007	$70,000	*Rates which are based on your spouse's age at the beginning of the calendar year will display on your individualized worksheet if the spouse's information is on file.*
002	$20,000		008	$80,000	
003	$30,000		009	$90,000	
004	$40,000		010	$100,000	
005	$50,000		**✓000**	**Waived Spouse Life**	
006	$60,000				

2009/2010 Benefits Enrollment Worksheet

Child Life Insurance

Your Choice
Option Code
Cost

	Option Code	Coverage Option	Cost Per Pay Period
	001	$5,000	$0.25
	002	$10,000	$0.50
	003	$15,000	$0.75
	004	$20,000	$1.00
✓	**000**	**Waived Child Life**	

Short Term Disability

Your Choice
Option Code
Cost

Option Code	Coverage Level	Cost Per Pay Period	Option Code	Coverage Level	Cost Per Pay Period
001	40% STD Coverage	*Your rates which are calculated on your base salary will display on your individualized worksheet.*	004	70% STD Coverage	*Your rates which are calculated on your base salary will display on your individualized worksheet.*
002	50% STD Coverage		✓**000**	**Waived STD Coverage**	
003	60% STD Coverage				

Health Care Flexible Spending Account

Annual Goal

(Pre-Tax Contribution)

When you enroll in the Health Care Spending Account, you may contribute from $26.00 to $5,200.00 for the plan year. The amount you elect will be divided by the number of pay periods in the plan year and taken from each paycheck.

You will default to no contribution if you do not make an election.

Dependent Care Flexible Spending Account

Annual Goal

(Pre-Tax Contribution)

When you enroll in the Dependent Care Spending Account, you may contribute from $26.00 to $5,000.00 for the plan year. The amount you elect will be divided by the number of pay periods in the plan year and taken from each paycheck.

You will default to no contribution if you do not make an election.

Employee Assistance Program

The Employee Assistance Program is provided to you at no cost.

Group Legal Services

Your Choice
Option Code
Cost

	Option Code	Coverage Option	Cost Per Pay Period
	001	METLAW Group Legal Services	$7.87
✓	**000**	**Waived Group Legal**	

ONLINE BENEFIT ENROLLMENT SYSTEM INSTRUCTIONS

1. Start your browser and type *https://portal.adp.com* in your address bar. Click on the "Go" button or press enter on your keyboard.

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2. At the initial ADP login screen, click on the "User Login" button as illustrated. A dialog box will prompt you to enter your User name that you received via email from *ADP_netsecure@adp.com*, and you Password you selected when you registered.

If not registered, go to PRISM Registration Instructions at: *http://ebc.maricopa.gov/hr/PRISM/pdf/SelfServiceRegistration.pdf* or click on "First Time Users Register Here" link. The registration pass code is MCAZ-PRISM09 (the last two digits are numbers zero and nine).
If you forgot your User name and/or Password, click the link that reads "Forgot your User Id" or "Forgot your Password".

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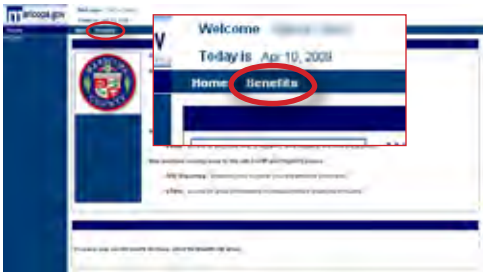
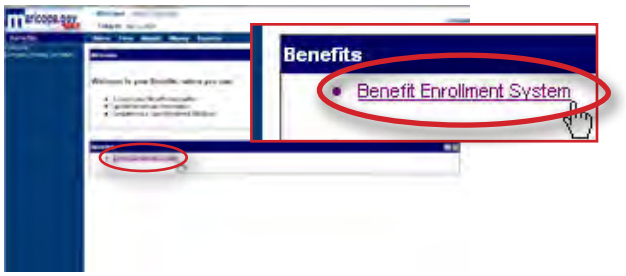
3. Once you are logged in, click on the "Benefits" tab as indicated in the image below.



On this next page, click on the "Benefit Enrollment System" link as shown.



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4. At the welcome page, click the "Continue" button to get to the "Main Menu" page.

The next screenshot shows the "Main Menu" page with the Instructions section link outlined. The instructions will guide you throughout the entire process. To proceed, click on the applicable link.

ONLINE BENEFIT ENROLLMENT SYSTEM INSTRUCTIONS

5. After clicking on the appropriate event link, your Benefit Summary will display.
   NOTE:
   After 15 minutes of inactivity, you will be logged out. Your changes will be saved as long as you go back and finish your elections by 8 PM MST the same day.

- The "Personal Information" section displays your demographic information such as your full name, address, birthday, etc.
- The "Dependents" section will show any current dependents that are linked to your profile. You can click on the dependent's name to display more information about him/her. You can also add a dependent by clicking on the "Add Dependent" button. To enroll a dependent in benefits you must complete the "Benefit Election" section described below.
- The "Benefit Elections" section will be pre-populated with your current or default elections. To change any benefits, click on the benefit link.
  Note: *To enroll a dependent, put a check mark next to the dependent for each benefit. If you uncheck a dependent from medical coverage, that dependent will be disenrolled for medical, pharmacy, vision, or behavioral health coverage.*
- The "Annual Account Elections" section will display the available benefit options according to your medical plan election.

  These elections are defaulted to waived unless you enter your Annual Contribution Amount in each benefit.
  To change any of your plan elections, click on the benefit link.
- The "Beneficiary Designations" section displays the designated beneficiary's name, relationship and percentage of designation for each life insurance benefit elected.

---

6. Once you are finished, review all your elections on the summary page and click on the "Submit" button to save your elections.
7. When you click on the "Submit" button, a pop-up window appears asking for your email address to send you an email acknowledgement. If you do not want the email acknowledgement, click on the "Cancel" button. Otherwise, enter your email address and click "OK".

ONLINE BENEFIT ENROLLMENT SYSTEM INSTRUCTIONS


2009 - 2010 Confirmation

You have successfully completed your enrollment.

Your Confirmation Number is 05841722.

Continue

Print

Personal Information

Name [redacted] Address [redacted]

Birth Date [redacted]

Base Salary [redacted]

[redacted]

USA

Dependents

Name	Relationship	Birth Date
[redacted]	Spouse	[redacted]

Benefit Elections

Benefit	Plan Election	Coverage	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Medical	Choice Fund Health Savings Account Benefits Plan	Employee plus Spouse [redacted]	$30.00	$424.01
Medical Waiver Credit Summary	Medical Waiver Credit Not Elected		$0.00	$0.00
Biometric Screening Incentive	I have completed Biometric Screening		-$5.00	$0.00
Health Risk Assessment Incentive	I have completed the Health Risk Assessment		-$5.00	$0.00
Non-Tobacco User Incentive	No one (me & covered dependent(s)) uses Tobacco products		-$20.00	$0.00
Pharmacy	Choice Fund HSA Pharmacy Benefit Plan	Employee plus Spouse [redacted]	$0.00	$0.00
Vision	Vision Benefit Plan	Employee plus Spouse [redacted]	$0.00	$4.95
Active Behavioral Health	Behavioral Health Benefit Plan	Employee plus Spouse [redacted]	$0.00	$0.00
Dental	Delta Dental Benefit Plan	Employee plus Spouse [redacted]	$26.31	$21.14
Basic Life Insurance	1 times Annual Base Salary		Company Paid	$3.00
Basic Accidental Death & Dismemberment	1 times Annual Base Salary		Company Paid	$0.60
Additional Life Insurance	5 times Annual Base Salary	Non-Tobacco User	$10.50	$0.00
Additional Accidental Death & Dismemberment	5 times Annual Base Salary	Employee plus Family	$5.31	$0.00
Spouse Life Insurance	$50,000		$2.50	$0.00
Child Life Insurance	Waived Child Life		$0.00	$0.00
Short Term Disability	60% Short term Disability Coverage		$20.90	$0.00
Employee Assistance Program	Employee Assistance Plan		Company Paid	$0.00
Group Legal Services	Waived Group Legal Services		$0.00	$0.00
		Total Employee Cost Per Pay Period:	$65.60	
		Total Employer Cost Per Pay Period:		$453.70

Annual Account Elections

Benefit	Plan Election	Before-Tax Contribution
Dependent Care Flexible Spending Account	Waive Participation	$0.00
Health Savings Account	Waived Contribution to Health Savings Account	$0.00
Limited Use Health Care Flexible Spending Account	Waived Limited Use Flexible Spending Account	$0.00

Beneficiary Designations

Basic Life Insurance

Name	Relationship	Percent	Designation
[redacted]	Spouse	90%	Primary
[redacted]	Beneficiary	5%	Primary
[redacted]	Beneficiary	5%	Primary

Basic Accidental Death & Dismemberment

Name	Relationship	Percent	Designation
[redacted]	Spouse	90%	Primary
[redacted]	Beneficiary	5%	Primary
[redacted]	Beneficiary	5%	Primary

Additional Life Insurance

Name	Relationship	Percent	Designation
[redacted]	Spouse	100%	Primary
[redacted]	Beneficiary	50%	Contingent
[redacted]	Beneficiary	50%	Contingent

Additional Accidental Death & Dismemberment

Name	Relationship	Percent	Designation
[redacted]	Spouse	100%	Primary
[redacted]	Beneficiary	100%	Contingent

8. The Confirmation page displays with your elections.
   Print a copy of this page for your records.
   A Confirmation Statement will be mailed to your home address.
   Compare the Confirmation page with the Confirmation Statement. If they do not match, contact the Employee Benefits Division within 15 calendar days.

---

9. Click the “Continue” button.

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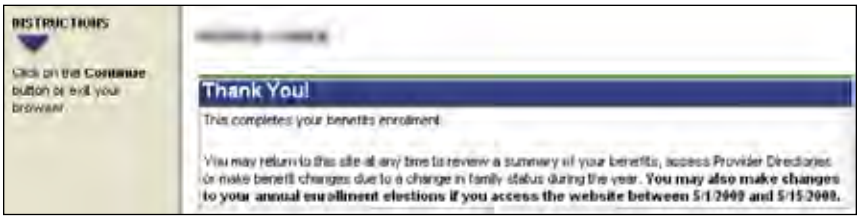
10. The last screen is the “Thank You!” page as shown below.
    When this displays, your benefit enrollment is complete.


INSTRUCTIONS

Click on the **Continue** button or exit your browser.

Thank You!

This completes your benefits enrollment.

You may return to this site at any time to review a summary of your benefits, access Provider Directories or make benefit changes due to a change in family status during the year. **You may also make changes to your annual enrollment elections if you access the website between 5/1/2009 and 5/15/2009.**

For a more detailed instruction set, go to:
http://ebc.maricopa.gov/ehi/pdf/2009/OE09/OEeventstoryboard.pdf


Benefit Enrollment System

2009-2010 Open Enrollment Event

For benefit-related questions call: (602) 506-1010

For system-related issues call your PC Help Desk or (602) 506-HELP

FY 2009-2010 PAYROLL SCHEDULE
USED FOR BENEFIT PREMIUM CALCULATIONS, COVERAGE EFFECTIVE DATES & COVERAGE END DATES

	Beginning	Ending	Pay Day
1	June 15, 2009	June 28, 2009	July 2, 2009
2	June 29, 2009	July 12, 2009	July 17, 2009
3	July 13, 2009	July 26, 2009	July 31, 2009
4	July 27, 2009	August 9, 2009	August 14, 2009
5	August 10, 2009	August 23, 2009	August 28, 2009
6	August 24, 2009	September 6, 2009	September 11, 2009
7	September 7, 2009	September 20, 2009	September 25, 2009
8	September 21, 2009	October 4, 2009	October 9, 2009
9	October 5, 2009	October 18, 2009	October 23, 2009
10	October 19, 2009	November 1, 2009	November 6, 2009
11	November 2, 2009	November 15, 2009	November 20, 2009
12	November 16, 2009	November 29, 2009	December 4, 2009
13	November 30, 2009	December 13, 2009	December 18, 2009
14	December 14, 2009	December 27, 2009	December 31, 2009
15	December 28, 2009	January 10, 2010	January 15, 2010
16	January 11, 2010	January 24, 2010	January 29, 2010
17	January 25, 2010	February 7, 2010	February 12, 2010
18	February 8, 2010	February 21, 2010	February 26, 2010
19	February 22, 2010	March 7, 2010	March 12, 2010
20	March 8, 2010	March 21, 2010	March 26, 2010
21	March 22, 2010	April 4, 2010	April 9, 2010
22	April 5, 2010	April 18, 2010	April 23, 2010
23	April 19, 2010	May 2, 2010	May 7, 2010
24	May 3, 2010	May 16, 2010	May 21, 2010
25	May 17, 2010	May 30, 2010	June 4, 2010
26	May 31, 2010	June 13, 2010	June 18, 2010

HOLIDAY SCHEDULE

	2009	2010
New Year's Day	Thursday, January 1	Friday, January 1
Martin Luther King Jr./Civil Rights Day	Monday, January 19	Monday, January 18
President's Day	Monday, February 16	Monday, February 15
Memorial Day	Monday, May 25	Monday, May 31
Independence Day	Friday, July 3	Monday, July 5
Labor Day	Monday, September 7	Monday, September 6
Columbus Day	Monday, October 12	Monday, October 11
Veteran's Day	Tuesday, November 11	Thursday, November 11
Thanksgiving Day	Thursday, November 26	Thursday, November 25
Christmas Day	Friday, December 25	Friday, December 24

NOTIFICATIONS

HIPAA Privacy Notice

In accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Maricopa County, in its role as the administrator and/or sponsor of the Employee Benefit Plan, or in its role as the health plan, makes available a notice setting forth its privacy practices through the EBC/Intranet *http://ebc.maricopa.gov/ehi* home page. This notice describes the potential uses and disclosures of Protected Health Information (PHI), the individual's rights and the plan's legal duties with respect to protected health information (PHI). The privacy notice may be updated occasionally and such updates will be communicated through *e*Nouncements*, accessible through the EBC.

Maricopa County's Group Health Plan - Notice of Privacy Practices

Maricopa County's Group Health Plan
Notice of Privacy Practices

The Health Insurance Portability and Accountability Act, otherwise known as HIPAA, requires Maricopa County to protect the privacy of your personal health information, and to provide you with this notice. HIPAA is a federal law that was effective April 14, 2003. The reason the law requires Maricopa County to provide you with this notice is because certain benefit programs administered through the Employee Health Initiatives Department are considered to be a Group Health Plan that is regulated by this law. This notice explains how your personal health information may be used, and what kind of rights you have under this law.

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Maricopa County offers a Group Health Plan (the "Plan"), which is a type of Health Plan, for eligible regular employees, certain contract employees, employees of affiliated organizations, retirees, and COBRA participants.

The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of your Protected Health Information (PHI)
- your rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services;
  and
- the person or office to contact for further information about the Plan's privacy practices

The term "Protected Health Information" ("PHI") includes all individually identifiable health information transmitted or maintained by the Plan whether oral, written, or electronic.

SECTION 1. NOTICE OF PHI USES AND DISCLOSURES

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.
Use and disclosure of your PHI may be required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The entities that provide coverage under your medical, prescription, behavioral health and substance abuse, dental, vision, flexible spending accounts, and COBRA, may share your PHI for treatment purposes, to get paid for treatment, or to conduct health care operations. Many of these entities may provide you with their own Notice of Privacy Practices. Refer to Table A for a list of the current entities that provide the above coverages.

The Plan and/or its business associates may use your PHI, without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment, and health care operations. For each business associate, the Plan has a written contract that contains terms to protect the privacy of your PHI.

The Plan may also share your information or allow the sharing of your PHI with Maricopa County as the Plan Sponsor for plan administration functions. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

Treatment is defined as the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. In addition, providers may share information with each other. The Plan does not use PHI for treatment purposes.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, premium payment, claims management, subrogation, coordination of benefits, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). For example, the Plan may tell a doctor (provider) whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to determine compliance with physician-issued prescriptions, refer you to a disease or case management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and Disclosures That Require Your Written Authorization

Your written authorization will be obtained before the Plan will use or disclose PHI for employer-related activities that include, but are not limited to, ombudsman activities which includes resolving your claims issue, fitness for duty examinations, short term disability claims, return to work program, employee assistance plan, ergonomics evaluations, wellness programs, workers' compensations claims, and care received at an on-site medical clinic. You may revoke your authorization in writing, at anytime, to stop any future uses or disclosures.

Certain types of PHI, including PHI regarding communicable disease and HIV/AIDS, drug and alcohol abuse treatment, and evaluation and treatment for serious mental illness, may have additional protection under state or federal law. Your written authorization is required in order to release this type of information.

Uses and Disclosures That Require You Be Given an Opportunity to Agree or Disagree Prior To the Use or Release

Disclosure of your PHI to family members, other relatives, and your close friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- you either have agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and Disclosures for Which Consent, Authorization, or Opportunity to Object Is Not Required

Use and disclosure of your PHI is allowed without your consent, authorization, or request under the following circumstances:

1. When required by law.

2. When authorized by law regarding when you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

3. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice could cause a risk or serious harm. For purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations, inspections, and licensure or for disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate health care fraud).

5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. When required for law enforcement purposes (for example, to report certain types of wounds).

7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

9. The Plan may use or disclose PHI for research, subject to conditions.

10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

SECTION 2. RIGHTS OF INDIVIDUALS

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made in writing to the **Employee Benefits Manager, at 301 S. 4th Avenue, Suite B100, Phoenix, AZ 85003**.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. *"Protected Health Information"* (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form. *"Designated Record Set"* includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made in writing to the **Employee Benefits Manager, 301 W. 4th Avenue, Suite B100, Phoenix, AZ 85003.** If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI

If you believe your PHI is erroneous or incomplete, you have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. You must make this request in writing and provide a reason to support your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made in writing to the **Employee Benefits Manager, 301 W. 4th Avenue, Suite B100, Phoenix, AZ 85003**. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request, but not before April 14, 2003. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based on your written authorization. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper copy of This Notice upon Request

To obtain a paper copy of this Notice, contact the **Employee Benefits Manager in writing at 301 W. 4th Avenue, Suite B100, Phoenix, AZ 85003.**

SECTION 3. THE PLAN'S DUTIES

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices. This is effective beginning April 14, 2003 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all participants for whom the Plan still maintains PHI. The notice will be distributed electronically via the Electronic Business Center (EBC) Intranet Benefit Home page. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individuals rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts no to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify and individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor or business associates for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

SECTION 4. YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE FOR CIVIL RIGHTS

If you believe that your privacy rights have been violated, you may complain to the Plan by writing to the Employee Health Initiatives Manager, 301 S. 4th Avenue, Suite B100, Phoenix, AZ 85003. You may file a written complaint, either on paper or electronically, by mail, fax, or e-mail with the Secretary of the Department of Health and Human Services. To obtain a copy of the complaint form or for more information about the Privacy Rule or how to file a complaint with Office for Civil Rights, contact any OCR office or go to www.hhs.gov/ocr/hipaa. Mailing address: Office for Civil Rights, U.S. Department of Health & Human Services, 50 United Nations Plaza – Room 322, San Francisco, CA 94102, Telephone (415) 437-8310, Fax (415) 437-8329, TDD (415) 437-8311. Visit the HHS OCR website at www.os.dhhs.gov/ocr/hipaa for more information. The Plan will not retaliate against you for filing a complaint.

SECTION 5. WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following individual: Employee Benefits Manager, 301 S. 4th Avenue, Suite B100, Phoenix, AZ 85003, telephone number (602) 506-1010, electronic mail: BenefitsService@mail.maricopa.gov

SECTION 6. CONCLUSION

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at *45 Code of Federal Regulations Parts 160 and 164*. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

TABLE A

Entity	Description of Coverage	Entity	Description of Coverage
CIGNA HealthCare of AZ	Medical	Magellan Health Services	Behavioral Health & Substance Abuse
Walgreens Health Initiatives (WHI)	Pharmacy	EyeMed Vision Care	Vision
CIGNA Dental	Dental	ADP	Flexible Spending Accounts
Delta Dental	Dental	ADP	COBRA
Employers Dental Services (EDS)	Dental		

EMPLOYEE ACKNOWLEDGEMENT

I hereby acknowledge receipt of this **Notice of Privacy Practices** and understand that is my responsibility to read the information contained herein.

Employee Name (printed) _____ Employee Signature _____ Date _____

Return your signed copy of this form to your Department HR Liaison

COBRA Initial Notification

This notice on possible future group health insurance continuation coverage rights applies individually to the following plan participants: **Employee, Spouse, and each covered dependent**.

It is being provided to you at this time because you have recently become, or are about to become, covered under a Maricopa County sponsored Health plan. It is important that all covered individuals take the time to read this notice carefully and be familiar with its contents. Should you add additional dependents in the future, notice to the covered employee and spouse at this time will be deemed notification to the newly covered dependent.

Plan Sponsor:

Maricopa County Employee Benefits Division
Workforce Management and Development Department
301 S. 4th Ave., Suite B100
Phoenix, Arizona 85003
Telephone number 602-506-1010
Fax number: 602-506-2354
Email: *BenefitsService@mail.maricopa.gov*

Plan Administrator:

ADP, Inc.
Telephone number 1-800-770-7981
https://www.benedirect.adp.com

Under federal COBRA law, should you lose your group health insurance because of one of the below listed qualifying events, covered employees and covered family members (called qualified beneficiaries) will be offered the opportunity for a temporary extension of health coverage (called Continuation Coverage) at group rates which you will be required to pay. This notice is intended to inform all plan participants, in a summary fashion, of your potential future options and obligations under the continuation coverage provisions of federal law. Should an actual qualifying event occur in the future, the plan manager will send you additional information and the appropriate election notice at that time. **Please take special note, however, of your notification obligations and procedures which are highlighted in this notification!**

*Qualifying Events for Covered Employee**

If you are the covered employee, you will become a qualified beneficiary and have the right to elect this health plan continuation coverage **if** you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

*Qualifying Events for Covered Spouse**

If you are the covered spouse of an employee, you will become a qualified beneficiary and have the right to elect this health plan continuation coverage for yourself **if** you lose group health coverage because of any of the following reasons:

1. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
2. The death of your spouse;
3. Divorce, or, if applicable, a legal separation from your spouse; or
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both).

*Qualifying Events for Covered Dependent Children**

If you are the covered dependent child of an employee, you will become a qualified beneficiary and have the right to elect continuation coverage for yourself **if** you lose group health coverage because of any of the following reasons:

1. A termination of the parent-employee's employment (for reasons other than gross misconduct) or reduction in the parent-employee's hours of employment;
2. The death of the parent-employee;
3. Parent's divorce, or, if applicable, a legal separation;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both); or
5. You cease to be eligible for coverage as a "dependent child" under the terms of the health plan.

*Rights similar to those described above may apply to covered retirees, and their covered spouses, and dependents if Maricopa County commences a bankruptcy proceeding under title 11 of the United States code and these individuals lose coverage within one year of or one year after the bankruptcy filing.

Employee/Qualified Beneficiary 60 Day Notification Requirement

Under group health plan rules and COBRA law, the employee, spouse, or other covered family members have the responsibility to notify the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the plan. Please read your summary plan description for specific information on when a dependent ceases to be a dependent under the terms of the plan. To protect your continuation coverage rights in these two situations, this notification must be made within 60 calendar days from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event. Procedures for making proper and timely notice are listed below.

1. Complete a Group Insurance Status Change form.
2. Make a copy of the form for your records.
3. Attach the required documentation depending upon the qualifying event.
4. Mail the notification form to the Plan Administrator and document your mailing.
5. Call the Plan Administrator within 10 calendar days to insure the notification form has been received.

If this notification is not completed according to the outlined procedures and within the required 60 day notification period, then rights to continuation coverage will be forfeited. In addition, keeping an individual covered by the health plan beyond what is allowed by the plan will be considered insurance fraud on the part of the employee.

If the qualifying event is a termination of employment, reduction in hours, death, enrollment in Medicare (Part A, Part B, or both), or for retiree coverage, a commencement of a bankruptcy proceeding, the employer will notify the Plan Administrator within 30 calendar days of the qualifying event.

Election Period and Coverage

Once the Plan Administrator learns a qualifying event has occurred, the Plan Administrator will notify qualified beneficiaries of their rights to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 calendar days to elect continuation coverage. The 60 calendar day election window is measured from the later of the date health plan coverage is lost due to the event or from the date of notification. This is the maximum period allowed to elect continuation coverage as the plan does not provide an extension of the election period beyond what is required by law. For each qualified beneficiary who elects group health insurance continuation coverage, coverage will begin on the date that coverage under the plan would be lost because of the event. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end and he/she ceases to be a qualified beneficiary.

If a qualified beneficiary elects continuation coverage, he/she will be required to pay the entire cost for the health insurance, plus a 2% administration fee. Maricopa County is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your coverage as well.

Length of Continuation Coverage - 18 Months

If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event. Exception: If you are participating in a health flexible spending account at the time of the qualifying event, you will only be allowed to continue the health flexible spending account until the end of the current plan year in which the qualifying event occurs.

Social Security Disability Extension - The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 calendar days of continuation coverage. In the case of a newborn or adopted child that is added to a covered employee's continuation coverage, the first 60 calendar days of continuation coverage for the newborn or adopted child is measured from the date of the birth or the date of the adoption. It is the qualified beneficiaries responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the Plan Administrator according to the below listed notification procedures within 60 calendar days after the date of determination and before the original 18 months expire. In general, if coverage is extended due to a Social Security Disability, premium rates may be raised to 150% of the applicable rate.

Secondary Event Extension - Another extension of the 18 or above mentioned 29 month continuation period can occur, if during the 18 or 29 months of continuation coverage, a second qualifying event takes place such as a divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent. If a second event occurs, during the original 18 or 29 months of continuation coverage, coverage will be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. It is the qualified beneficiaries responsibility to notify Maricopa County according to the below listed notification procedures within 60 calendar days of the second event and within the original 18 or 29 month continuation timeline. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not a second event.

Social Security Disability/Second Qualifying Event Notification Procedures

1. Complete the COBRA Qualifying Event Notification form.
2. Make a copy of the form for your records.
3. Attach the required documentation depending upon the qualifying event.
4. Mail the notification form to the address listed on the form and document your mailing.
5. Call within 10 calendar days to insure the notification form has been received.

Length of Continuation Coverage - 36 Months

If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under the Maricopa County Employee Health Insurance Program, then each dependent qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

Eligibility and Premiums

A qualified beneficiary does not have to show they are insurable to elect continuation coverage, however, they must have been covered by the plan on the day before the event to be eligible for continuation coverage. An exception to this rule is if while on continuation coverage a baby is born to or adopted by a covered employee qualified beneficiary. If this occurs, the newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of the original qualifying event. Procedures and timelines for adding these individuals can be found in your Know Your Benefits booklet and must be followed. The Plan Administrator reserves the right to verify continuation eligibility status and terminate continuation coverage retroactively if a qualified beneficiary is determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary will have to pay all of the applicable premium plus a 2% administration charge for continuation coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, Maricopa County can charge up to 150% of the applicable premium during the extended coverage period. Qualified beneficiaries will be allowed to pay on a monthly basis. In addition there will be a maximum grace period of 31 calendar days for the regularly scheduled monthly premiums.

Cancellation of Continuation Coverage

The law provides that if elected and paid for, your continuation coverage will end prior to the maximum continuation period for any of the following reasons:

1. Maricopa County ceases to provide any group health plan to any of its employees;
2. Any required premium for continuation coverage is not paid in a timely manner;
3. A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act;
4. A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare;
5. A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
6. A qualified beneficiary notifies the Plan Administrator he/she wishes to cancel continuation coverage.
7. For cause, on the same basis that the plan terminates the coverage of similarly situated non COBRA participants.

Should continuation coverage be terminated for one of the above reasons, a notice will be sent to you at that time.

Notification of Address Change

In order to protect your group health insurance continuation coverage rights and to insure all covered individuals receive information properly and efficiently, you are required to notify the Plan Administrator of any address change as soon as possible. Failure on your part to do so will result in delayed notifications or a loss of continuation coverage options.

Any Questions?

Remember, this notice is simply a summary of your potential future continuation coverage options and not a description of your actual health benefits under the plan. For questions regarding your health benefits, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator. Should an actual qualifying event occur and it is determined that you are eligible for continuation, you will be notified of all your actual rights at that time. Should you have any questions regarding the information contained in this notice, you should contact the Maricopa County Employee Benefits Division, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at *www.dol.gov/ebsa*.

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call CIGNA Customer Service for more information.

Obtaining a Certificate of Creditable Coverage under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact ADP COBRA Customer Service.

General Notice of the Plan's Pre-existing Condition Exclusion

The Open Access Plus In-Network plan, the Open Access Plus High and Low plans, and the Choice Fund Health Savings Account plan impose a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 60 calendar days prior to your effective date of coverage. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 calendar days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months from your first day of coverage. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage."

- Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days.
- To reduce the 12-month exclusion period by your creditable coverage, you should give CIGNA a copy of any certificates of creditable coverage you have.
- If you do not have a certificate, but you do have prior health coverage, you should contact your prior plan and ask them for a certificate of creditable coverage. Please contact the Employee Benefits Division at (602) 506-1010 if you need help demonstrating creditable coverage.

Notice of Special Enrollment Rights

In general, IRS restrictions prevent you from making changes to your coverage elections during the year. This means that once you make your health plan elections at Open Enrollment, you may not drop dependents or change your coverage until the next Open Enrollment period. You may be able to add or drop dependents during the plan year if you experience and report a life event, also known as a status change. These changes include the following:

- You get married or divorced.
- You acquire a dependent child through birth, adoption or placement for adoption.
- Your spouse or dependent dies.
- Your dependent no longer meets the plan's eligibility requirements.
- Your spouse terminates employment or begins new employment.
- You or your spouse change from part-time work to full-time work (or vice-versa).
- You or your spouse have a significant change in health care coverage.
- You are required to provide dependent medical coverage as a result of a valid court decree that meets the requirements of a Qualified Medical Child Support Order (QMCSO).

Any benefit enrollment change you make must be consistent with your qualified status change. To change your coverage, you must call the Employee Benefits Division at (602) 506-1010, complete the status change form and provide documentation of the change within 30 calendar days of the date you experience the status change. Your new elections will be effective on either the date of your status change or the date your status change was processed, and retroactive payroll deductions may be withheld. If you do not call within the 30 calendar day period, you must wait until the next Open Enrollment period to change your benefits.

WHO TO CONTACT

Maricopa County Employee Benefits Division
Workforce Management and Development Department
Chambers Building
301 South 4th Avenue, Suite B100
Phoenix, Arizona 85003-2145
(602) 506-1010
Fax: (602) 506-2354
TTY: (602) 506-1908
EHI Home Pages { *www.maricopa.gov/benefits* / *http://ebc.maricopa.gov/ehi*
BenefitsService@mail.maricopa.gov
Benefit Enrollment System: *https://portal.adp.com*

Medical Plans

CIGNA - *Group #3205496*
24- Hour Customer Service - (800) 244-6224
Pre-Enrollment Questions - (800) 401-4041
24-Hour Health Information Line - (800) 564-8982
Health Savings Account Customer Service - (866) 524-2483
Well Aware Disease Management - (800) 249-6512 to enroll
or (877) 888-3091 for questions
Healthy Pregnancies, Healthy Babies - (800) 615-2906
Healthy Rewards - (800) 870-3470
Technical Assistance for Health Assessment - (800) 853-2713
www.cigna.com
www.mycigna.com
www.mycignaplans.com
(username: Maricopa2009 / password:cigna)

*Pharmacy Plans**

Walgreens Health Initiatives - *Group #512229*
Member Services - (800) 207-2568
Prior Authorization - (877) 665-6609
Walgreens Mail Service Member Service - (888) 265-1953
Mail Service Refills - (800) 797-3345
Specialty Pharmacy - (888) 782-8443
Medication Therapy Management - (866) 352-5310
www.mywhi.com

*Behavioral Health / EAP**

Magellan Health Services - *Group# N/A*
(888) 213-5125
www.magellanassist.com

Vision

EyeMed Vision Care - *Group# 9750076-Refraction; 9750092-LASIK; 9750118-Acute Care*
Customer Service - (866) 723-0514
Pre-Enrollment Questions - (866) 299-1358
LASIK - (877) 5LASER6
www.eyemedvisioncare.com

Dental

Employers Dental Services - *Group #11931-Plan #300R*
(602) 248-8912 or (800) 722-9772
www.mydentalplan.net

CIGNA Dental - *Group # 2465354*
(888) 336-8258
www.mycigna.com

Delta Dental - *Group # 4500*
(602) 938-3131 or (800) 352-6132
www.deltadentalaz.com

*Contact CIGNA for Rx & mental health for Choice Fund plan

Life Insurance

The Standard - Policy #645547
(888) 414-0396
www.standard.com/mybenefits/maricopa

Short-Term and Long-Term Disability

Sedgwick CMS - Group# 435000
Short Term Disability - (800) 599-7797
Long Term Disability - (800) 495-9301
www.sedgwickcms.com/calabasas

Retirement

Arizona State Retirement System - (602) 240-2000
Outside Phoenix - (800) 621-3778
www.azasrs.gov/web/index.do

Public Safety Retirement System
(602) 255-5575
www.psprs.com

Nationwide Retirement Solutions:
Deferred Compensation
(602) 266-2733
(800) 598-4457
www.maricopadc.com

Other

Automatic Data Processing, Inc. (ADP)
Flexible Spending Accounts
(800) 654-6695
Claim & Substantiation Fax: (866) 392-4090
www.flexdirect.adp.com

Liberty Mutual: - Group #8871
Auto, Home and Renters Insurance
(800) 221-8135
www.libertymutual.com

MetLaw® - *Plan 150 / Group #0518*
(800) 821-6400
http://info.legalplans.com (password - 1500518)

Automatic Data Processing, Inc. (ADP)
COBRA Administrator
(800) 770-7981
Call for applicable fax number
https://www.benedirect.adp.com

Biometric Screening Administrator
CIGNA Onsite
(800) 694-4982 from April - May
Call 602-506-1010 between June - March
https://www.cignascreenings.com/maricopa